The Complexities Embedded in Family-Centered Care

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The recent movement toward family-centered care, which has been propelled by the implementation of the Education for All Handicapped Children Amendments of 1986, poses considerable challenges to professionals trained in client-centered models of service delivery. These challenges are compounded by the fact that our understanding of family-centered care lags considerably behind our attempts to implement responsive and efficacious services. When practitioners include family members more integrally as collaborators in pediatric treatment, their perceptions about families and the nature of the therapeutic experience is affected. In this article, we present a number of critical dilemmas that are based on data drawn from ethnographic research, descriptive studies, and training seminars we conducted with pediatric practitioners and parents of children with special health care needs. These dilemmas highlight the complexities involved in building effective partnerships among all the key players, the influence of multiple cultural worlds on everyday practices, and the need to provide supports to practitioners for the emotional and social dimensions of practice. Implications for practice and future research are presented.

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Pediatric occupational therapy practice has undergone expansion during the past 25 years because of federal policy initiatives, generation of new knowledge related to human development, and development of occupational therapy theories. This expansion has also been marked by foundational shifts in the ways that therapy is delivered. Some of the most dramatic changes in pediatric practice have occurred through the emergence of family-centered care.

Health care practitioners and policymakers have recently embraced principles of family-centered care as the organizing framework for services for infants and young children with special health care needs (e.g., Education for All Handicapped Children Amendments of 1986 [Public Law 99-457]) (Maruyama et al., 1997; Shelton, Jeppson, & Johnson, 1992). Additionally, recent research in developmental psychology and an accumulation of evidence to support transactional models of development have created a climate in which early childhood practitioners have recognized the power of family members as change agents (Pearl, 1993), the importance of nurturing facilitative environments for children with special health care needs (Sameroff & Fiese, 1990), and the need to adopt ecological models for designing interventions (Provence, 1990). The recognition that parents are the main constant in a child's life has contributed to the perception of the patent as the primary resource for promoting a child's development (Leff & Walizer, 1992; Shelton et al., 1992).

In occupational therapy, the concept of working with families is not new (e.g., Knickerbocker, 1965; McKibbin, 1972; Mendoza, 1969; Robeson, 1926; Whitehead, 1956), but the ways in which practitioners involve family members has changed. One marker of this change is the explicit attention on practice models designed to involve family members collaboratively in contrast to previously prevalent compliance and expert-driven models of services. Family-centered care models designed to support reciprocity and collaboration have only emerged since the late 1980s (e.g., Baum, 1991; Hasselkus, 1991; Hinojosa, 1990; Schaaf & Mulrooney, 1989). During the past decade, authors have been more attentive to the potential influence of therapy on parent-child interactions (Humphry, 1989; Unger & Howes, 1988), home programs (Hinojosa & Anderson, 1991), and family life (Hinojosa, 1990). As family-centered care is implemented, more articles related to particular challenges (Humphry, 1995) and aspects of implementation are appearing, including evaluation and intervention processes (Clark, Corcoran, & Gitlin, 1995; Gitlin, Corcoran, & Leinmiller-Eckhardt, 1995), and attitudes of practice-
special education programs. In addition, special education
article is not a report of our ethnographic findings, we
sessions were conducted through a pilot study supported
study followed 20 families who had children enrolled in
themes are neither all inclusive nor definitive but are pre­
the challenges inherent in providing family-centered care.

Critique of Current Family-Centered Models

Family-centered approaches typically presume that move­
to family-focused practice can simply supplement
traditional health care models. The notion that involving
family members can simply be “added on” to the practi­
cioner’s current practice neglects the fact that contempo­
rary health care service systems still, by and large, value
and reward therapeutic interventions that narrowly ad­
ress the child’s specific physical needs rather than his or
her diffuse social and cultural needs or the concerns and
the values of the child’s primary caregivers. Furthermore,
shifting decision-making power to the consumer requires
professionals to spend considerable time negotiating deci­
sions with family members, which may lessen the amount
of time spent on “hands-on” treatment. Shifts in this
direction are not easily added on to traditional medical
practice because they threaten many assumptions about
best medical practices.

Family-centered approaches are also typically ground­
ed in the belief that family members and practitioners
develop “equal partnerships” (e.g., Dunst & Paget, 1991;
McGonigel, Kaufmann, & Johnson, 1991). However, the
underlying assumption that the types of relationships
developed between families and practitioners are based on
equality is problematic (Howard & Strauss, 1975). Prac­
titioners and families often bring very different perspec­
tives to the intervention. Traditionally, the practitioner
has been viewed as the expert and, in the authoritarian
role of expert, assumes a hierarchical position over the
parent (e.g., Cunningham & Davis, 1985). In models of
family-centered care, these perspectives should be com­
plementary and facilitative for identifying areas of mutual
interest and sharing respect. Perspectives of both parties
should be altered as they grow and consider new informa­
tion brought about through a collaborative process.

One flaw in the equality assumption is that equality
of partnerships is often operationalized in terms of degree
of respect, decision-making power (Case-Smith & Nas­
tro, 1993), and responsibility for implementing the inter­
vention plan. However, little or no emphasis is given to
other central elements of the service delivery process,
including problem setting and identification, assessment
or diagnosis, critique of treatment options, and determi­
nation of intervention efficacy. These latter elements tend
to structure the nature of the therapeutic interaction and
can preclude effective family participation in decision making. Decisions about such things as what constitutes an appropriate assessment tool or appropriate outcome measure are most likely to be determined not by the individual practitioner and family member, but by a larger institutional context. That is, the process by which problems are defined, treatment options are discussed, and treatment efficacy is measured are powerfully shaped by practitioners’ institutional contexts. Even when a practitioner and family member are eager to create an effective partnership, the way practice is traditionally structured, particularly within institutional cultures, can make such a partnership difficult to form.

Assessment provides an excellent example. The problem identification process (typically done through diagnostic and evaluation procedures conducted by the expert) is critical in shaping the structure of professional–client and professional–family relationships. Evaluation of a child’s functional and physiological deficits, for instance, provides more than information; it sets the parameters for treatment goals, which are subsequently identified. Once deficits have been identified, the professional then links them with certain techniques and skills designed to address them. The problem-setting phase is one in which the role of family members is particularly constrained. Although family members are often involved in initiating a referral or expressing concerns (Brinker, 1992), their involvement in framing the problem is limited. Their contributions are influenced by what they are asked, the extent to which their information is considered salient, the extent to which they are viewed as credible witnesses, and the degree of compatibility of their beliefs with those of the practitioner. Difficulties intensify when there are substantial cultural or socioeconomic gulfs between practitioners and families, for here mistrust and confusion can abound about the roles expected of each. Even the notion of what constitutes “family” comes into question.

Although many proponents of family-centered models prescribe training for health professionals in better interpersonal skills, the difficulties facing occupational therapy practitioners who struggle to collaborate with family members cannot be ameliorated simply by introducing innovative interpersonal skills. Innovation at the individual level must be paired with a recognition of how the individual’s clinical encounters with family members are influenced by the cultural world of practice. Likely, incorporation of a family-centered model of care into practices requires innovation at multiple levels, from individual practice to the broader structural and institutional practices (e.g., scheduling of appointments) that shape how individual practitioners perceive their role and the role of family in evaluation and treatment of children.

Despite the generation of multiple publications articulating the principles of family-centered care (e.g., Bishop, 1993; Edelman, Greenland, & Mills, 1993; McGonigle et al., 1991; Shelton et al., 1992), understanding of the actual experiences of family members and practitioners who attempt to engage in collaborative relationships is still limited. Although many studies designed to address the question of early intervention efficacy have incorporated variables measuring parent involvement (e.g., White, Taylor, & Moss, 1992), research on the role of family members provides conflicting data. For example, Shonkoff and Hauser-Cram (1987) concluded from their meta-analyses of more than 30 studies of children with disabilities that the type and extent of parent involvement in intervention affected child developmental outcomes. However, White and Castro (1985) conducted an integrative review of 162 studies, predominately of children who are disadvantaged and environmentally at risk, and found little difference in effect sizes on the basis of degree of parent involvement. Integrative reviews have also provided little support to the assumptions that services targeted at parents are more cost-effective or result in better long-term outcomes (White et al., 1992). Research designed to assess the efficacy of family-centered care is sparse (Brinker, 1992), and most of the integrative reviews draw on published studies that predate the implementation of family-centered services. These reviews, and many others, serve more to highlight the methodological problems endemic to efficacy research in providing early childhood services than to validate or discredit the assumptions underlying the family-centered care movement.

The oversimplification of practice embedded in current models of family-centered care is currently unchallenged partly because of a paucity of good research on the complexities of collaboration between pediatric health care practitioners and families. Adequate models of family-centered care require a more fine-grained analysis of day-to-day perspectives, values, assumptions, and practical dilemmas facing practitioners and families as they struggle to create effective partnerships. Research efforts need to be situated in the clinical encounters within the both the practitioners’ and families’ cultural worlds if we are to generate the understandings needed to promote more helpful models of family-centered care.

Situating Family-Centered Care in Cultural Contexts

The article draws from interview data, both narrative and focus group, with therapists and families, and thematizes a number of key challenges that are recurrent refrains. Many of these are not major catastrophic events that prevent partnerships from being effective but, rather, are small, persistent obstacles and differences in perspective, which are difficult to surmount. We conceive of these
challenges as “daily dilemmas” of practice, or routine spontaneous events occurring within the context of therapy that create a dissonance between what practitioners believe should be occurring and the actual experiences that occur in intervention situations. Many dilemmas that pediatric occupational therapy practitioners raise reflect their struggle to include families in a more substantive way while still attempting to “fit into” the norms and values associated with the “culture of biomedicine.” These typical practical difficulties and frustrations are often not created by the actors involved, but are generated or exacerbated by the “clinic culture.”

Occupational therapists, like other health care professionals, practice in a culture world, a “culture of biomedicine” (Lock & Gordon, 1988; Rhodes, 1993). This cultural world strongly influences the decisions of health care professionals, including occupational therapy practitioners, shaping clinical reasoning about how problems are defined and what treatment is deemed appropriate. Occupational therapists do not treat children or collaborate with family members in an institutional vacuum. Their capacities to develop effective relationships depend, to a significant degree, on the institutional environment in which they work. The environmental culture, particularly in a hospital setting, carries powerful messages about what health care practice ought to look like. Even when therapists practice outside hospital settings (e.g., home health, schools), much of the way practice is defined, including professional roles, assessment tools, treatment techniques, and outcome measures, have been derived from the culture of biomedicine (Lock & Gordon, 1988; Rhodes, 1993). This culture offers powerful assumptions about the characteristics of good health care practice that shape the behavior of practitioners; their definitions about the nature of their work; and their communication and interaction with colleagues, consumers, and the consumers’ families. Some of these assumptions are outlined in the next sections, with particular attention to their influence on the practitioner’s capacity to develop partnerships with family members.

Professional as Expert

The expert model of treatment, where the professional is presumed to be an applied scientist using value-neutral knowledge and techniques to diagnose and treat clients, is a key feature that dominates clinic culture (Feinstein, 1973). Practices steeped in medical traditions frequently adopt professional–client relationships on the basis of hierarchical models or expert-driven models (Cunningham & Davis, 1985). In the expert model, the consumer’s contribution to the relationship is often restricted to providing information and demonstrating compliance with the intervention plan proposed by the expert. In addition, hierarchical relationships often depend on the client’s acceptance of the expert’s power and demonstration of respect for the professional’s expertise. Partnerships are rarely reciprocal.

Because the expert model is so pervasive, even when health care professionals work to involve family members in the health care process, they are likely to be attuned to a compliance model of partnership in which they see their task as persuading family members to “buy into” a particular course of treatment action (Lawlor & Cada, 1993; Mattingly, 1991b). Not surprisingly, reliance on expert models fosters relationships between practitioners and family members in which collaboration is equated with compliance. The tension between asking family members to collaborate or to comply with professional perspectives becomes most evident when conflicts arise. Conflicts can arise when practitioners perceive that a dissimilarity with family perspectives creates a collision of principles (McWilliam & Bailey, 1993) or a struggle to achieve balances in power (Shonkoff, Hauser-Cram, Krauss, & Upshur, 1992). Power and control tend to be solidified within the realm of the practitioners (Tostle, 1988), resulting in the devaluation of the needs and contributions of family members.

The Nature of “Real” Work

A second significant feature of clinic culture concerns the way professionals define work. In our research, we found that practitioners divided their interactions with clients into “real treatment” and what they variously called “making the patient (or family member) comfortable,” “chit chat,” “establishing rapport,” and the like (Mattingly & Fleming, 1994). Real treatment was a label offered by practitioners for the sort of treatment intervention they could report in the charts and at staffing meetings, the sort they had been trained to offer in their formal schooling, and that they could report to insurance companies (Mattingly, 1991a, 1991b). A practitioner may informally report to colleagues, “I couldn’t get much real work done in the session today. Johnny’s mother was very upset about his need for a wheelchair, and I just felt I had to spend time talking to her instead.” In this typical remark, it is apparent that the practitioner feels torn between fulfilling her professional responsibilities to provide real treatment to the child and an equally compelling concern to attend to a family member’s concerns about the child’s condition. The clinic culture is likely to support the practitioner’s first concern, but make it difficult for him or her to justify the second. The ideal of real treatment, as this term is informally used by practitioners, is an intervention that is well-bounded; addresses discrete problems;
and has the following characteristics: (a) is grounded in medical knowledge of physiology and pathology, (b) addresses problems identified by standardized assessment and diagnostic procedures, (c) bases interventions on a particular set of techniques for which the practitioner had been specifically trained, and (d) is restricted to interventions whose outcomes can be measured such that progress can be quantitatively marked. Treatment is considered more real and legitimate when it involves these characteristics.

Service Fragmentation and Specialization

The third key feature of clinic culture that influences the ability of practitioners to create effective partnerships with family members is service fragmentation and specialization. Institutionalized structures in health care encourage or even demand multiplicity of highly specialized professionals addressing different aspects of the child's problems. Rigid specialization tends to create "turf battles" as professionals struggle to maintain autonomy from one another. In addition, high degrees of specialization are often associated with gaps in service delivery, miscommunications, and limited attention to the more mundane or routine dimensions of problems that are not easily associated with one discipline or across discipline boundaries. Attempts to respond to needs identified by family members, which do not fit the practitioner's delineation of specialized services, often illuminate gaps in the service network when interdisciplinary coordination and service integration are insufficient.

Professional fragmentation among professionals, even ones working together on interdisciplinary teams, means that cultural differences are not located solely between the worlds of clinic and family. Professional dilemmas do not merely emerge as practitioners attempt to straddle dissimilar clinic and family cultures. Although in the past social theorists have sometimes depicted the clinic culture as a homogeneous whole (Foucault, 1973), a growing body of literature in medical anthropology and sociology (e.g., Good, 1994; Lindenbaum & Lock, 1993; Lock & Gordon, 1988; Rhodes, 1993) and our own research and training of occupational therapy, physical therapy, and other practitioners in pediatric and early childhood settings reveal that this is not the case. Occupational therapy, physical therapy, and other early childhood professionals identify the same child's problems in different ways. They see the child and the disability differently. Thus, the child and family members travel from service to service, working with professionals who each may have his or her own definition of the child's problem (Mattingly, 1993).

Daily Dilemmas Within Family-Centered Care

Practitioners find themselves in conflict as they try to maintain their role as experts while striving to connect interventions to the expressed needs of the family. Practitioners are often drawn to individualize treatment goals to meet the particular concerns of clients and family members. This is largely because early childhood practice depends on the client and family members playing an active role in treatment. Thus, the problem of motivating clients and family members to participate actively in treatment tends to draw practitioners into the world of the client and family as they try to discern how to create a treatment program that would motivate a child to work hard and take on challenges. The concern to direct practice toward the individualized contextual needs of the child tends to create conflict with qualities characterized as real treatment. Individualization of treatment leads practitioners to value interventions that have the following characteristics: (a) stray from standardized techniques as practitioners improvise to create special activities particularly suited to the client's life; (b) involve "common sense" and complex everyday activities that do not rely on standardized equipment and procedures; (c) are not as easily measurable; (d) involve important actors in the client's social world (e.g., parents, siblings, neighbors, friends); and (e) reflect an appreciation of the cultural meanings of routine intervention events (e.g., feeding, motoric independence) (Mattingly, 1990–1993, #H023H00005; 1991b).

These tensions and conflicts are ones pediatric therapists are likely to face every day in one form or another. Although these dilemmas are not peculiar to practitioners who attempt to draw family members more directly into partnership, they tend to be exacerbated by the struggle to develop effective partnerships with families. The following sections delineate several key dilemmas that emerged from our data.

Practitioner Dilemmas

Who is the client? Practitioners have traditionally been trained to work in a "hands-on" way with the child. In trying to address family needs, they struggle with the dilemma of just who the client is. Practitioners believe that their traditional way of working and measuring their own effectiveness as practitioners comes under threat as they are asked to involve family members in therapy. Involving family members, if more than a matter of enlisting their help as therapy aides, means coming to understand the issues confronting them in trying to care for their child. But this inclusion of family members means that the health care problem itself broadens and changes so that practitioners become increasingly less clear about their own role and increasingly plagued by shifts in decision-making power and responsibility for
implementation. Practitioners report that their role as specialists who work on a well-defined set of problems becomes blurred as they try to become increasingly attentive and responsive to family needs concerning the child.

**Turf difficulties.** Involving family members and addressing their concerns for the child tend to threaten the already fragile boundaries among professional specializations, exacerbating turf difficulties. Good service to families almost seems to demand an interdisciplinary team approach, requiring a considerably higher level of professional coordination than currently exists. There are two reasons for this: (a) Family members often value treatment or high degrees of coordination among professionals, and (b) family members rarely identify concerns or goals that fall neatly into particular specializations. Accomplishing objectives critical to family life often means increased interdisciplinary collaboration among practitioners. Data from our earlier research supports that the shift in approach may need to be radical, involving a conversion to team models that are based on interdependence. A common professional dilemma concerns the pull to coordinate and expand services to meet family needs and the opposing pull to define treatment in a narrow and highly specialized way that better accords with the current organization of health care delivery and payment structures. When misunderstandings or conflicts arise in the constructions of meanings that are shared between practitioners and family members, efforts are often made to negotiate or impose the practitioner's understanding (Brincker, 1992).

**Expert or friend?** Several parents have described their best relationships with practitioners as "just like family" or as a "friend." Practitioners have expressed their discomfort with family members who become "too dependent" or "cross the line" in terms of their expectations for the practitioners. They become troubled when the underlying social contracts inherent in these relationships are seemingly violated.

**Where is the family?** Because many family configurations, particularly among low-income ethnic minorities, do not follow the nuclear family pattern, family structures and role expectations may baffle many middle-class health professionals who expect to see families that match their own life experiences of a "real" or "functional" family. This often causes tremendous dilemmas for practitioners who do not know how to develop a collaborative relationship with a family constituted in unfamiliar ways. This dilemma is challenging and emotionally laden for many practitioners, one that is exacerbated when practitioners serve clients from different cultural backgrounds than their own whose family roles and even family membership may be differently defined (Mattingly, 1990–1993, #H023H00005). For example, we found that practitioners had difficulty discovering how to develop collaborative relationships with some low-income families whose ethnic background differed from that of their own.

**Bottomless pit anxieties.** Many practitioners believe that if they start to become involved in the concerns and emotional lives of families, they will be inundated with issues that they are not prepared to handle. In some situations, practitioners believe that efforts to support the family and deal with the emotional and social issues take time away from the "real work" of intervening directly with the child. Furthermore, practitioners feel a strong lack of formal training or available models for addressing family needs. Practitioners report believing that to hear a problem implies responsibility for addressing the problem.

**Family Dilemmas**

Family members too, live in and create family cultures that may make it difficult to understand how to collaborate with practitioners in the treatment of their child. In interviews with parents, we found the following dilemmas and difficulties.

**The likability of the child.** In their descriptions of emotionally laden events, many parents have discussed the need to know that practitioners value their child as a human being, enjoy being with their child, and "engage" with their child. Our observations have included many intervention events in which the mother "gives voice" to the child by expressing the child's feelings or wishes or hidden attributes (e.g., "he really likes you," "she's really very intelligent"). This aspect of giving voice may also take the form of explicitly stating something that the mother believes should have been realized through mind reading or interpreting behavioral cues (e.g., "he wants you to stop"). As we explored this theme, we identified many subthemes that relate to cultural beliefs about mothering, the process of parental attribution, and the emergence of a sense of self in early infancy (Cicchetti & Beeghly, 1990; Stern, 1985).

**The good parent–bad parent syndrome.** Parents described repeated instances in which they perceived that they were judged when they attempted to fully insert their voice into the service delivery process. In the most obvious analysis of this phenomenon, we identified clear remnants of hierarchical, expert-driven, and compliance models of partnerships (Cunningham & Davis, 1985). However, less obvious subthemes emerged. These include "the need to be nice," "the costs of being candid," and "making good impressions." Practitioner judgments that a person is "noncompliant" or, in the terms used by family members, "a bad parent," divert energies away from more reflective analysis or direct attempts to under-
stand alternative perspectives (Trostle, 1988).

Implicit social contracts. Family-centered services are constructed around numerous social contracts of expected behaviors, which our research shows are rarely made explicit. In trying to understand what this meant to parents, we have listened to many examples that turned out to be violations of implicit social contracts. Parents cited as examples "failing to call me when you say you will," "keeping me waiting for long periods," "not letting me know what's going on," and "not clearly telling me what you are thinking." Additional examples concern interdisciplinary team meetings. Parents reported, and we have observed, that professionals often do not explicitly address the social rules that surround a team meeting. The problem is compounded in teams in which professionals are highly socialized into reporting practices that leave little room for parent participation. The dilemmas for parents include: "When do I get to talk?" "Is it OK to interrupt?" and "Am I here to say what I think, or is my role just to listen?"

A different sense of time. Many parents have shared experiences related to differing perceptions of time horizons. Practitioners trained in a medical model approach often focus on the here and now and short-term time dimensions, such as 3-month or 6-month intervals. Parental narratives reveal a dramatically different view of time. They are much more future oriented and express deep frustration in difficulties they experience in engaging practitioners in scenario building for the future. Their future is not a discharge date but often spans 20 years, even an entire life. Subthemes include hope and expectations, finding a place for their child in society, and problem setting.

Culture brokers. Typically, the mother of the child in need of services attends intervention programs, clinic appointments, and interdisciplinary planning meetings. The role entails serving as the family representative and conveying the perspective on the family issues as well as representing the practitioner perspective and clinical events to the family. This is a complex role where the family representative becomes, in effect, a "culture broker" whose difficult task is to bridge the clinic culture with the family world (Brinker, 1992). This role often places the mother in the position of interpreting for others both the information exchanged and the meanings behind complex sets of experiences. In addition, the mother often acts as the messenger in attempting to modify the expectations of either the practitioners or family members to accommodate the needs of the other party. Although family-centered care presumes practitioners are involved with the entire family system, our experiences indicate that a model that reflects the central role of one family member and the complexities inherent in that member's role as culture broker is needed.

Conclusion

We recognize that we have presented a rather gloomy picture of the state of the family-centered care movement. Current practice models are inadequate; there is a paucity of good research that may better inform models of practice; and the dilemmas facing practitioners and families are deeply intertwined with institutional and cultural structures of practice. We have deliberately highlighted the difficulties and complexities involved in "becoming family-centered." Our presentation of the differing perspectives of family members and practitioners reflects our appreciation of their respective experiences in doing family-centered care. The themes that we have presented somewhat simplistically here are in reality multilayered. They often emerged through emotionally laden stories and statements. Neither practitioners nor family members who we have studied took these challenges lightly, nor do we.

Movement from client-centered to family-centered models of services, we have said, requires a redefinition of practice. Additive models for adopting innovations provide inadequate direction for the transition to family-centered models of intervention. We believe that any successful movement toward family-centered care will be actualized only when the radical nature of the required social shift in human services is recognized. Foundational shifts are required in the definition of the nature of the work (e.g., What counts as real therapy?), the distribution of power in treatment relationships, professional identity, measurement of desirable treatment outcomes, and the organization of service delivery systems. Future research efforts should examine (a) the processes by which members of health care teams develop relationships with families that have a child with special needs and collaborate in the delivery of services, (b) the meanings of illness and disability in the context of family life, (c) the characteristics of family-centered practice, and (d) the influences of organizational structures and professional cultures on the delivery of services.

Despite the enormity of changes needed to actualize a family-centered approach to practice, our research has also shown that practitioners and family members often do develop effective partnerships. They find ways to work together, to attend to one another's needs and concerns, and to come to understand (and even appreciate) the other's differing point of view. In other words, family-centered care happens. Practitioners told compelling stories of such instances, and as researchers, we have witnessed unlikely partnerships develop between practitioners and families despite major ethnic, cultural, or class differences or difficult institutional environments. How did they get started? Why do these partnerships work?
What can be learned from these successful experiences that could be taught to other practitioners, inform policy, or be incorporated in models of family-centered care? As in many things, family-centered practice is ahead of theory. If adequate practice models are to be developed, we must attend to practice as it now occurs, including both the dilemmas that make things difficult and the successes that have yet to be examined and analyzed.

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**Cordelia Myers Writer’s Award**

The American Occupational Therapy Association is pleased to announce that Lynn Hooley has been chosen as the recipient of the Cordelia Myers Writer’s Award for the 1997 AJOT volume year. The paper, “Circumventing Burnout in AIDS Care,” published in the October issue, was considered by the AJOT Editorial Board members to be a strong piece of professional writing by a first-time contributor to AJOT during the 12-month period. The AJOT Editorial Board and staff members extend their congratulations to Lynn Hooley.