Are We Parent-Friendly? Views of Parents of Children With Emotional and Behavioral Disabilities

Harriette C. Johnson, David E. Cournoyer, June Fliri, Miriam Flynn, Andrea M. Grant, Maryanne A. Lant, Spero Parasco, & Edward J. Stanek

Abstract

A current model of family-centered practice emphasizes empowerment of parents, an approach that brings together a strengths perspective, a constructivist emphasis on consumer voices, and knowledge derived from neuroscience of the last two decades. This study explored the extent to which a national random sample of National Association of Social Workers members hold beliefs and attitudes congruent with the parent empowerment perspective. Two profiles emerged from the data. Respondents who disagree with statements attributing blame to parents agree with sharing information openly with parents; believe that parents are doing their best, are credible reporters, and are experts about their own children; agree that workers need research knowledge; and disagree that the child is usually the identified patient in a a dysfunctional family. By contrast, respondents who believe parents cause their children's emotional and behavioral problems disagree with open information sharing; disagree that parents are doing their best or are experts about their own children; agree that the child is an identified patient in a dysfunctional family; and agree that parents' ideas are important mostly to give the worker clues about family dynamics. The majority of the sample reported parent-friendly views, but a substantial minority of respondents reported beliefs antithetical to parent empowerment.

A CURRENT MODEL OF FAMILY-CENTERED *practice, emphasizing empowerment of parents, was first* launched on a national scale by the National Institute of Mental Health in 1984 through the creation of the Child and Adolescent Service System Program (CASSP). This major initiative stressed involvement of families in all aspects of child mental health planning and implementation (Stroul and Friedman, 1994). Contemporary empowerment models are a continuation of CASSP directives that programs should be family-centered and should use a collaborative approach in working with families (Duchnowski, Johnson, Hall, Kutash, & Friedman,1993). Parent empowerment is now endorsed by social work in child welfare as well as mental health (National Child Welfare Resource Center for Family-Centered Practice, *2000*; Early & GlenMaye, *2000*; Callahan & Lumb, 1995). This study explored the extent to which social workers hold beliefs and attitudes congruent with the parent empowerment perspective.

In the empowerment approach, parents are seen not as targets of change efforts but as the focus of services and interventions intended to support them, such as respite care, family support groups, and advocacy. There is a new appreciation of the importance of the relationship between the parents, extended kin, and formal and informal supports within the community. Parent participation extends to involvement in planning and overseeing services at the sys-

Families in Society: The Journal of Contemporary Human Services

tem level. That is, they should be partners not only in direct service delivery to their own children but also in designing and delivering services (Hara & Ooms, 1995).

This approach, often referred to as "parent-friendly," represents a paradigm shift away from entrenched belief systems that feed into a bias against families, from the legacies of schizophrenogenic mothers and dysfunctional families (Stroul & Friedman, 1994; Johnson, Cournoyer, Fisher, McQuillan, Moriarty, Richert, Stanek, & Yirigian, 2000; Knitzer, 1982). In contrast to a traditional view of parents as dysfunctional, the source of the child's pathology, and lacking competence and expertise with respect to their children, the new paradigm sees parents as a resource, identifies their strengths, and perceives them as experts about their own children. The parent empowerment approach brings together a strengths perspective, a constructivist emphasis on consumer voices, and knowledge derived from neuroscience research of the past two decades (Mental Health: A Report by the Surgeon General, 1999; Saleebey, 1996; Goldstein, 1990; Weick, Rapp, Sullivan, & Kisthardt, 1989). Thus it appears to span the divide between postmodern and scientific viewpoints.

Despite the increasing endorsement of parent empowerment approaches to practice, there is evidence that parents are still unhappy not only with overt behaviors on the part of professionals, but also with their perceived attitudes. Some areas of concern include attribution of blame; failing to share information, explain specific ways in which parents can help their child, teach coping skills, or involve parents in treatment decisions; not valuing parents' expertise about their own children; not keeping up-to-date with current research; and not helping parents find other services when unable to help (Mohr, 2000; Biegel, Song, & Milligan, 1995; Johnson, Cournoyer, & Bond, 1995; Friesen, 1989). It is widely accepted that positive relationships between parents and providers can further efforts to help children and adolescents, and conversely that negative exchanges may impede the helping process (Mohr, 2000; Petr & Allen, 1997; Biegel et al., 1995; Johnson et al., 1995). These professional attitudes and behaviors, if really present, may thus threaten parent–professional collaboration in behalf of children.

For example, parents surveyed by Johnson, Cournoyer, and Bond (1995) rated workers who valued parents' expertise, shared information with parents, respected parents' ideas about treatment alternatives, and explained specific ways to help their children, as "best" professionals, in contrast to "worst" professionals who attributed blame, did not share information with parents, failed to involve parents in treatment decisions, and did not appear to respect parents' opinions about their own children. Moreover, professional deficiencies in some of these areas translated into violations of professional ethics as set forth in the National Association of Social Workers (NASW) Code of Ethics (1995). Thirty-four "experts" on professional ethics, identified by the national office of NASW, rated the questionnaire items used in the survey in relation to the ethical principles comprising the Code of Ethics. Most questionnaire items were found to correspond with at least one ethical principle, and many questionnaire items corresponded with several ethical principles. Based on these ratings, parent reports of professional behaviors involved violation of several ethical principles such as providing clients with complete and accurate information about risks, limits, rights, and opportunities associated with service (informed consent); serving clients with compassion and respect for human dignity; respecting the client's right to self-determination; helping find other services when unable to help; recognizing the limits of and not attempting to treat beyond the bounds of one's competence; not abandoning the client until arrangements have been made for other services; keeping abreast of new knowledge and new developments in the field; and seeking advice and consultation in the interests of clients (Johnson et al., 1995).

In the present study, NASW members were surveyed about their views of parents of children with emotional and behavioral disabilities. The population of social workers from which the survey sample was drawn was the entire membership of NASW. Since the membership is a broad and diverse group representing all fields of practice, practice settings, and geographical areas in the United States, we designated it "general" as contrasted with the subsets of "clinical" social workers whose views have been reported in two recent studies (Rubin, Cardenas, Warren, Pike, & Wambach, 1998; Johnson, Renaud, Schmidt, & Stanek, 1998).

The designation "clinical" in the two studies referred respectively to 261 social work practitioners licensed in a southern state as "advanced clinical practitioners" (Rubin et al., 1998) and to a random sample of the subset of NASW members who have designated themselves as "clinical" and are listed in the NASW Register of Clinical Social Workers (NASW, 1993; Johnson et al., 1998). Findings by these two studies were similar, and disheartening; they indicated that a substantial number of clinical social workers have failed to keep abreast of current knowledge about etiology of mental and emotional disorders, and furthermore that many clinical social workers hold views that parents and parent advocates deem blaming, demeaning, or otherwise disrespectful.

The authors wondered what the views of social workers across populations and practice settings would be. The study reported here assessed overall levels of parent empowerment beliefs and attitudes among a random sample of general NASW members nationwide, and compared their views with those of clinical social workers previously reported.

Previous studies have suggested a connection between cognizance of current neuroscience and parent-friendly beliefs. Professionals still guided by theories of etiology of psychiatric disorders that predate the neuroscience revolution often have reported a profile of beliefs antithetical to the parent empowerment perspective (Rubin et al., 1998;

Johnson & Renaud, 1997). Research shows clearly that a range of disorders, from "major" psychiatric illnesses such as schizophrenia, major depression, and bipolar disorder to other psychiatric conditions such as attention-deficit hyperactivity disorder, Tourette's syndrome, obsessive–compulsive disorder, and panic disorder, are predominantly the manifestations of underlying neurobiological conditions (Mental Health: A Report by the Surgeon General, 1999). That is, they are illnesses in a body organ or system (the brain, the central nervous system) comparable to nephritis as an illness of an organ (the kidney) or diabetes as an illness of a body system (metabolic). Biological contributors to these conditions include genetics; viral or bacterial disease; head injury; toxic effects of environmental contaminants; perinatal events involving lack of oxygen; prematurity; and many others. These facts do not, however, minimize the role of the environment. Research confirms that observable manifestations of psychiatric disorders are typically responsive to *interactions* between biological, psychosocial, and environmental forces, not "just" biological or "just" environmental factors. Inputs from the environment can precipitate or exacerbate symptoms of biological disease already present in the brain and the central nervous system (Mental Health: A Report by the Surgeon General, 1999).

To investigate the extent to which NASW members hold parent-friendly beliefs, the Providers' Beliefs About Parents Questionnaire (PBAP) was used. The PBAP measures views pertaining to certain themes that appear frequently in the parent/professional collaboration literature (Johnson, Cournoyer, & Fisher, 1994). These themes are: (a) Some professionals believe that a combination of biological and environmental factors cause emotional and behavioral disorders, whereas others attribute etiology of children's emotional, mental, and behavioral problems almost entirely to parental practices or dysfunctional family relationships. (b) Some professionals believe that information should be shared openly with parents including information about the risks of treatment, the limits of the professional's knowledge, and the current scientific knowledge base pertaining to causes of and treatments for their children's conditions. Other professionals believe that parents are incompetent to understand or make productive use of this information, therefore it should be withheld from parents. (c) Some professionals view parents as caring, knowledgeable about their own children, and willing to learn new skills to improve their parenting. Other professionals see parents as disengaged, enmeshed, rejecting, controlling, or chaotic. (d) Some professionals believe that children and adolescents with emotional, mental, and behavioral problems are often helped by psychotropic medication, whereas others believe that medications are harmful and should be used only as a last resort, if at all. (e) Some professionals believe that they should directly teach parents skills for coping with their children's behavior, whereas others believe they should treat the child's "dysfunctional family" or should give parents individual psychotherapy for their own emotional problems. Professionals who think parents are the ones who need treatment often do not teach parents skills because they believe that would not get to the "root" of the problem, that is, sick families or sick individual parents. The research reported in this article reflected the authors' sense that professional beliefs systems relating to these themes—that is, their "mental models" (Carlson, 1985)—can either contribute to collaborative practice with parents, or can adversely affect collaboration. Although we were unable to find any rigorous quantitative studies documenting comparative outcomes when an identified parent/professional collaborative process was and was not in place, the literature is replete with qualitative literature based on interviews with parents that suggest such connections. This literature can be accessed through mental health-relevant databases (Medline, PsycInfo) using keywords such as "parent–professional collaboration," "professional beliefs and parents," and "parents and blame."

The issue of attributing children's emotional and behavioral problems to inadequate or noxious parental influences is complex. On the one hand, there is ample reason to believe that years of repetitive interactions between parents and children profoundly influence what children learn about people, the world, and themselves. On the other hand, recent studies demonstrate remarkable emotional and behavioral similarities between identical twins separated at birth, reared by different parents, and unknown to each other until a reunion in their 30s or later in life (Bouchard & Hur, 1998), attesting to the powerful influence of genetics in determining adult personality. Furthermore, longitudinal studies tracing children's development from birth to adulthood demonstrate that some children emerge from horrendous childhood circumstances as well-functioning adults, whereas other children reared in benevolent family environments manifest serious emotional problems in adulthood (Werner, 1989; Elder, 1974). In Werner's seminal study, inborn temperament and biological stressors at birth on the one hand (biological factors), and socioeconomic resources on the other (environmental factors), are the variables most associated with adult outcomes. That is, these biological and environmental risk and protective factors, not dysfunctional versus functional families, are the major contributors to characteristics associated with adult mental health or illness.

In a recent analysis of all existing prospective longitudinal studies, Kagan and Zentner (1996) concluded that these studies, taken as a whole, support only a modest relationship between psychological profiles in the first 4 years of life and later psychopathology, and only in two areas. The most consistent findings imply that extreme impulsivity in preschool male children predicts adolescent delinquency, and that certain neuromotor abnormalities in infants may sometimes

indicate vulnerability to adult schizophrenia. Both of these categories of precursors to delinquency and schizophrenia are known to be constitutional or genetic in origin (Peschel, Peschel, Howe, & Howe, 1992). By contrast, there were no data from prospective longitudinal studies linking parenting practices during the first four years of life to adult psychopathology.

These findings do not in any way contravene the belief that poor parenting can cause unhappiness. They indicate simply that as of now there are no longitudinal data linking poor parenting in these years with later psychological illness. Nor do they contravene the belief that for children with risk factors for psychiatric disabilities, lack of parental knowledge and understanding of the child's vulnerability, and corresponding lack of special skills needed to reduce these risks, can exacerbate an emotional or behavioral disability. However, the attribution of etiology of psychiatric disorders to parents is quite different from inferring that parental behaviors can cause unhappiness or exacerbate symptoms of psychiatric disorders in their children.

Yet Rubin and colleagues (1998) found in their survey of licensed clinical social workers that in relation to major psychiatric disorders, not only did 57% of respondents agree that parental dysfunction is a primary cause of serious mental illness, but half of all respondents also believed that an aim of therapy should be to get family members to understand how their family dynamics have helped cause their relatives' severe mental illness. That is, believing parents are to blame appears to translate into behaviors that convey this belief to parents.

In the second study of beliefs of clinical social workers referred to above (Johnson et al., 1998), data pertained to emotional and behavioral disorders in general, not just those specified as major mental illness. For a sizeable minority of clinical social workers, parent concerns appeared to be justified. For example, about one third of respondents disagreed that parents are experts about their own children, more than a third disagreed that professionals should share all information openly with parents, and one fifth disagreed that parents are doing their best (Johnson et al., 1998).

For a majority of the sample, parent blaming emerged as a major issue. More than two-thirds of respondents agreed with the statement "Family dynamics are usually the major cause of children's emotional disorders." In addition to neglecting the findings of recent neurobiological research, this belief also overlooks questions such as: To what extent does inability to find steady employment, threat of job loss, or chronic exposure to drugs and violence shape or influence family dynamics? Do the repeated negative reactions of teachers, neighbors, friends, and the child's peers to the child's inappropriate or annoying behaviors, arouse feelings of shame, humiliation, or impotence in the parents? Do such feelings influence parents' emotions and behaviors? How does living in a dangerous crime-ridden neighborhood, with chronic threats to physical safety, affect family dynamics? (a question tied closely to issues of societal discrimination against people of color, who disproportionately suffer the impacts of living in such environments). These questions convey recognition that family dynamics themselves are often responses to a range of other forces, both environmental and biological.

The notion that family dynamics cause a child's problems distorts the more complex chains of causality in which the observed family dynamics are far along in a complicated series of causes and effects. Family dynamics themselves are often effects—responses to other variables such as biologically based difficult behaviors in the child, major threats to physical or economic survival, and/or pervasive social ostracism (Bronfenbrenner, 1979; Aronson, 1999; Lewis & Balla, 1976; Elder, 1974; Miller, 1978). To reframe these dynamics as the causes of the child's or adolescent's problems, then, does appear to suggest a tendency to blame parents unfairly.

There is a long history of reports of incorrect assessment of chains of causality, as in the following examples from the 1970s and earlier. The first vignette pertains to a family with three children, two of whom did well socially and academically. Until a third child showed characteristics of {undiagnosed} ADHD, called "minimal brain dysfunction" in the 1970s, the couple had been happy and the family had been regarded in the community as a model of successful family life.

> *Everyone called my son Christopher emotionally disturbed. He's very bright—his IQ tests at 160—but he was nearly thrown out of kindergarten. He was constantly fighting with the other children and getting into trouble. My wife and I begged the school to keep him—she was going crazy having him at home. I paid almost a third of my salary in therapy fees. We couldn't afford babysitters, and vacations were out of the question. We couldn't do much as a family because Chris would always act up and make a scene. My wife and I fought all the time because we each could see the other doing things wrong. (Johnson, 1980)*

In this example, the conflict between the parents was the fallout from having a child with a behavioral disorder: chronic exhaustion, frustration experienced by both parents because none of the various parenting practices they tried was successful, economic losses incurred because of the child's disability, inability to engage in family activities because of the child's behaviors, and reluctance by the school to keep the child because of these behaviors (perhaps with innuendos suggesting parental culpability). The conflict became expressed in mutual recriminations by desperate parents unable to obtain appropriate diagnosis and treatment. Undoubtedly the parents did "do things wrong," as most parents do at times, but there was no evi-

dence that their arguments *caused* their son's out-of-control behaviors. This vignette illustrates a marital conflict that resulted from, rather than caused, a behavioral disorder.

Dorothy Lewis, well-known researcher on delinquency who has documented the high rates of neurological disability in court-referred youth, has written:

> *We have found that even hospitals and child guidance clinics, encountering extraordinarily rejecting parents, often tend to attribute the child's disturbance primarily to the parents' attitudes. It is often hard to recognize that the parents' forceful rejection of their children is frequently a response to the children's chronic disruptive behavior for which no help was received. After seeing a number of such initially well-meaning but ultimately rejecting parents, we came to recognize a situation we dubbed "the abused parent." As we came to know these parents, we found that although they were, indeed, furious at their children, their anger seemed at times to be more a response to the child's unmanageable behavior—coupled with the failure of others to appreciate this—than an initial cause of the child's disturbance. (Lewis & Balla, 1976, p. 109, p. 21)*

Another example pertained to impacts on family dynamics of a macrosystem event, the Great Depression. In a 20-year longitudinal study of 145 children reared during the Depression, the economic losses suffered by families were found to have resulted in *a restructuring of family relationships in many of the families* (emphasis added). Significant changes in socialization took place. The mother often emerged as a central figure in decision-making as well as the primary emotional resource for the children. The prestige, attractiveness, and perceived power of the father was frequently weakened. Male victims of the Depression often blamed themselves and were blamed by others for their job and income failures when in fact the causes lay in the socioeconomic system. Family members often attributed the father's loss of the breadwinner role to his personal inadequacies. The self-esteem of the children was also affected adversely. Children in families whose income had dropped 40% or more were found to have distorted perceptions of how others saw them. They believed that they were held in lower esteem by their peers than was actually the case. (adapted from G. Elder, *Children of the Great Depression*, 1974, University of Chicago Press)

Once again, family dynamics were responses to other variables, not autonomous forces originating in the families. In this example, a societal force (major economic reversal) shaped family dynamics. The literature is replete with examples of effects of systems of different sizes on family dynamics. The reader is referred to Bronfenbrenner (1979) for a well-developed exposition of the operations of complex chains of causality.

Methods

The questions previously posed in relation to clinical social workers were addressed in this study of NASW members. What are the beliefs of a cohort of NASW general members? Are they more congruent with a parent empowerment perspective than those reported by samples of clinical social workers?

Sample. Participants in the study were selected by systematic random sampling of the 1995 general membership list for the National Association of Social Workers (NASW) which had 153,814 members. The NASW general membership sample was about .5% of the entire register (702 questionnaires mailed out). Nonresponder samples were obtained with a combination of a third mailing and follow-up phone calls, with 16.9% of the NASW general sample falling into the nonresponder category. No significant differences were found between responder and nonresponder samples with respect to demographic variables or scores on the belief factors measured by the instrument. Therefore, the nonresponder sample was included in the overall sample. Data from the earlier study based on an NASW subset of clinical social workers, drawn from the 1993 edition of the National Association of Social Workers Register of Clinical Social Workers, were used for comparison (Johnson et al., 1998).

Instrument. The Providers' Beliefs About Parents questionnaire (PBAP) used for the survey was composed of Likert-scaled items with four possible responses: Strongly Agree (1), Agree (2), Disagree (3), and Strongly Disagree (4). The instrument was assessed using test–retest reliability, exploratory, and confirmatory factor analysis (see Johnson, Cournoyer, & Fisher, 1994, for a report of psychometric properties). Validation of the instrument was recently replicated using national random samples of providers (N = 1,464) that included social workers, psychologists, and child psychiatrists (Fisher, 1998). In the replication on these different populations, including the population from which this study sample was drawn (NASW members), the confirmatory factor analysis reported in the validation study was repeated.

The PBAP questionnaire was intended to be responsive to parent concerns as reported in the literature by measuring professional views of parents' competence, parents' pathology, parents' credibility, parents' role in the etiology of children's problems, information sharing with parents, and giving explicit directives to parents about how to help their children. Two additional issues were included as questionnaire items that have implications for work with parents: the use of psychotropic medication with children and adolescents, and the perceived importance of research-based knowledge about child and adolescent mental and emotional problems. Practitioners who regularly update their knowledge by reading reports of recent research may hold

different attitudes from those who operate predominantly from information dating from the 1970s and 1980s (Rubin et al., 1998).

Items on the PBAP clustered into five factors:

Factor 1. Attribution of causality (factor named "Blame"), composed of items expressing beliefs that parents cause their children's emotional or behavioral disabilities through poor parenting, their own emotional dysfunction, or harmful family dynamics. The choice of blame as the factor name reflected definitions of blame as attribution: "to hold responsible," "to place responsibility for," "to find fault with," connoting "malfeasance or errors of ignorance, omission, or negligence" (Merriam-Webster, 1988, p. 157; Aronson, 1999; Kelley, 1967).

Factor 2. Belief that providers should share information openly with parents with regard to etiology, alternative interventions, possible benefits and risks of treatment, and costs (factor named "Inform").

Factor 3. Beliefs that express a validating attitude toward parents (e.g. parents are doing their best, are credible reporters of their children's behavior, have expertise about their own children, and can teach professionals helpful responses to their children) ("Validate").

Factor 4. Helpfulness of psychotropic medication for children and adolescents with emotional and behavioral problems ("Medicate").

Factor 5. Belief that providers should give parents explicit instructions about ways to help their children ("Instruct").

Six individual items on the PBAP, eliminated from factor analysis because of low loadings, were retained as single items because of their conceptual importance. Three of the individual items expressed parent empowering beliefs and the other three expressed beliefs antithetical to a parent empowerment perspective. These items amplified two profiles of professionals' beliefs and attitudes, which are reported with results. The six items follow.

- In mental health work with children, practitioners need current research-based knowledge about psychopathological conditions of children and adolescents.
- Medical journals are a good source of information about emotional disorders.
- Family dysfunction is often a reaction to a child's biologically based difficult behavior" (beliefs congruent with the parent empowerment perspective).
- When a child is referred for disturbed behavior, he or she is likely to be the identified patient in a dysfunctional family.
- It is rarely necessary for me to refer families with an emotionally disturbed child to professionals in other disciplines.
- Parents' views about their emotionally disturbed child are important mostly to give the worker clues about family dynamics" (beliefs antithetical to the parent empowerment perspective).

Data Collection Procedures. Three mailings and follow-up phone calls yielded responses from 425 NASW general members (60.5% response rate). To address the question of difference between NASW general members and NASW clinical social workers, previously reported data on views of NASW clinical social workers using the same instrument (Johnson et al., 1998) were compared statistically with views of respondents in the present sample.

Analysis. Descriptive statistics were obtained for all individual belief items and for the five belief factors, with adequate distribution after appropriate transformations for two variables. Frequencies were obtained for categorical predictors (ethnicity, gender, partnership status, professional discipline, practicing with children and their parents, and approach to practice with families having a child with a mental or emotional disability). MANOVAs (multivariate analysis of variance) were used to test levels of agreement of categorical items with each of the five belief factors. Correlations with the five factors were obtained for continuous predictors (age, years in practice, number of children, income, and number of parent support groups listed). Discrete and continuous variables that related to belief factors at $p < .10$ were retained for further analysis.

Weighted factor scores for the five factors were used in multivariate analyses. Unweighted mean summary scale scores, corresponding directly to the Likert scale item values (1–4), were used for simple comparisons to facilitate interpretation (Kleinbaum, Kupper, & Muller, 1988; Kim & Mueller, 1990).

For mean differences, significance testing was supplemented with effect size measures (Cohen, 1992, 1994). Methodological details are available from the senior author.

Results

Demographic variables. These variables are presented in Table A1 in the Appendix. Females predominated ($n = 274$, 69.5% of respondents), but slightly less so than in three recent surveys of NASW membership (75%–79% female) (Gibelman & Schervish, 1997). Distribution by gender did not differ between NASW general members and clinical social workers. Representation of African Americans was higher for the NASW general sample than the clinical sample ($\chi^2 = 16.6$, $df = 4$, $p < .002$, adjusted standardized residual (ASR) 3.3). There were no other differences by ethnicity between the two samples. More than a third of respondents ($n = 158$, 37.2%) worked with children, adolescents, and their parents, with no difference on any beliefs about parents between respondents who did and did not work with child or adolescent populations. General NASW members were much less likely than clinical social workers to be in private practice (27.0% vs. 58.8%, $\chi^2 = 78.4$, $df = 1$, $p < .000001$), somewhat less likely to work in adult mental health outpatient settings (26.8% vs. 37.1%, $\chi^2 = 5.3$, $df = 1$,

Table 1. *Five Belief Factors and Six Individual Items: NASW General Member and Clinical Social Worker Samples*

Variable	NASW General			NASW Clinical			Mean Difference	CI Mean Difference	*t*	Cohen's *d*	Effect Size
	n	Mean	*SD*	*n*	Mean	*SD*					
Factor 1. Attribution of blame.	390	2.76	.53	318	2.54	.50	-.22	-.30, -.14	-5.62***	.4	medium
Factor 2 Providers should share information openly.	403	1.98	.41	324	2.05	.39	.07	.01, .13	2.45*	.2	small
Factor 3. Validating beliefs about parents.	392	2.06	.40	318	2.07	.37	.01	-.05, .06	.37		
Factor 4. Medication is often helpful.	406	2.36	.51	320	2.50	.50	.14	.07, .22	3.85***	.3	small
Factor 5. Providers should give parents explicit instructions about how to helptheir children.	412	1.83	.60	328	1.81	.53	-.02	-.10, .06	-.49		
Practitioners need current research-based knowledge.	423	1.64	.66	333	1.69	.63	.05	-.04, .14	1.01		
Child is the identified patient in dysfunctional family.	413	2.19	.65	331	1.98	.60	-.21	-.31, -.12	-4.62***	.3	small
I rarely need to refer to families with a child with emotional disturbance to other disciplines.	408	2.97	.65	326	2.92	.67	-.05	-.15,	.04	-1.03	
Parents' views important mostly as clues re family dynamics.	410	2.19	.78	330	2.22	.72	-.03	-.08,	.14	.56	
Medical journals a good source about emotional disorders.	400	2.39	.66	324	2.48	.64	.09	-.04,	.19	1.88	
Family dysfunction often a reaction to child's biologically based difficult behavior.	409	2.39	.69	323	2.52	.66	.13	-.03, .22	2.50*	.2	small

*$p < .05$. ***$p < .001$.

$p < .02$), and more likely than clinical social workers to work in child and family services (14.9% vs. 6.0%, $\chi^2 = 15.3$, $df = 1$, $p < .00009$).

The results reported in the remaining tables shed light on the two research questions that motivated the study: "To what extent does a general social work sample of NASW members hold parent empowering beliefs?" and "How do their beliefs compare with those of clinical social workers?"

Descriptive statistics. Mean scores of 1–2 indicate agreement, 3–4 indicate disagreement, and mean scores of 2–3 indicate some agreement and some disagreement. Values from 1.00–2.20 were interpreted as "mostly agree," values of 2.80–4.00 were interpreted as "mostly disagree." Table 1 presents descriptive statistics for the five belief factors and six individual questionnaire items among general NASW members. With respect to attributing blame to parents for their children's emotional and behavioral disorders, and to helpfulness of medication, mean scores were between 2 and 3, indicating some agreement and some disagreement. On average, respondents agreed with sharing information openly with parents, agreed with validating beliefs about parents, and agreed with giving parents explicit instruction about how to help their child. A minority of respondents disagreed or partially disagreed with these three items. We will later examine Table 1 for comparisons between general NASW members and clinical social workers.

Table 2 shows associations between beliefs or attitudes and theoretical orientations for NASW general members. On average, general members who endorsed an ego psychological/psychodynamic orientation agreed more with attributing blame to parents, agreed less that professionals should share information openly with parents, and agreed less with validating beliefs about parents, than did nonendorsers. Respondents endorsing a cognitive–behavioral orientation agreed more that professionals should give parents explicit instructions about how to help their child. Endorsers of a neuropsychological orientation agreed more that medication is often helpful. Respondents endorsing family systems and existential/humanistic orientations did not differ significantly from nonendorsers on any belief factor in the general member sample. Effect sizes for these differences were small, except for a large effect size for neuropsychological orientation, with endorsers much more likely than nonendorsers to see medication as helpful.

Preferences with respect to practice approach also were associated with differences in beliefs. The practice approaches include: help parents talk about their feelings toward each other and their child, hold family therapy sessions where interpersonal sequences between members can be enacted, and teach parenting skills using modeling, behavioral rehearsal, and homework. Respondents who preferred to teach parenting skills held more validating beliefs about parents than respondents who preferred to help parents talk about feelings (mean difference = .12, $t = 2.42$, p

Table 2. *Associations Between Theoretical Orientations and Parent-Friendly Beliefs and Attitudes Among NASW General Members*

	n	Mean	*SD*	Mean Difference	CI Mean Difference	*t*	Cohen's *d*	Effect Size
Ego psychological/Psychodynamic								
Attributes blame to parents								
Endorses ego psychology	181	2.71	.57	-.10	-.21, .003	-1.91[a]	.2	small
Doesn't endorse	208	2.81	.48					
Agrees with sharing information openly with parents								
Endorses ego psychology	188	2.03	.40	.10	.02, .18	2.37*	.2	small
Doesn't endorse	214	1.93	.42					
Holds validating beliefs about parents								
Endorses ego psychology	179	2.10	.41	.08	-.00, .16	1.89[a]	.2	small
Doesn't endorse	212	2.02	.39					
Cognitive-Behavioral								
Agrees that professionals should give parents explicit instructions about how to help their child								
Endorses cognitive-behavioral	157	1.72	.55	-.17	-.29, -.05	-2.77**	.3	small
Doesn't endorse	252	1.89	.62					
Neuropsychological								
Agrees that medication is often helpful								
Endorses neuropsychological	12	1.86	.58	-.51	-.80, -.22	-3.45***	1.0	large
Doesn't endorse	392	2.37	.50					

[a] $p \leq .06$. *$p < .05$. **$p < .01$. ***$p < .001$.

< .05). They also held more validating beliefs than respondents who preferred to hold family therapy sessions (mean difference = .12, $t = 2.11$, $p < .05$). Preference for teaching skills was also associated with agreement that professionals should give parents explicit instructions about how to help their child (mean difference from talking about feelings = .28, $t = 4.17$, $p < .001$; mean difference from holding family therapy sessions = .26, $t = 3.13$, $p < .01$). Thus preferring to teach skills to doing psychotherapy or family therapy was the approach most congruent with a parent empowerment perspective. Effect sizes for differences in beliefs by practice approach ranged from small (for holding validating views about parents) to medium (for giving parents explicit instructions about how to help the children).

Correlations among the five belief factors and and six individual items. The correlations between factors in this study of NASW members replicate earlier data sets based on different (larger) populations (Johnson & Renaud, 1997). Attribution of blame correlates negatively with agreeing with sharing information openly ($n = 380$, $r = -.176$, $p < .001$), and negatively with agreeing with validating beliefs ($n = 374$, $r = -.339$, $p < .001$). Agreeing with sharing information openly and agreeing with validating beliefs correlate positively with each other ($n = 385$, $r = .426$, $p < .001$). Agreeing that professionals should give explicit instructions to parents about how to help correlates positively with sharing information ($n = 397$, $r = .347$, $p < .001$) and with validating views ($n = 386$, $r = .190$, $p < .001$).

Table 3 amplifies profiles of the two contrasting belief sets by showing correlations between the five belief factors and six individual questionnaire items. In one belief set, respondents agree with sharing information openly with parents, agree with giving parents explicit instructions about how to help their child, and agree with views that comprise the validation factor—that is, that parents are doing their best, are credible reporters, are experts about their own children, and can teach professionals how to help them and their children. These respondents agree that psychotropic medication is often helpful and/or necessary for children and adolescents with emotional and behavioral disabilities. They agree that workers need research knowledge, and that family dysfunction is often a reaction to having a child with biologically based difficult behaviors. They disagree with statements attributing causality to parents, disagree that parents' ideas are useful mostly as clues to family dynamics, disagree that they seldom need to refer families of such children to other disciplines, and disagree that the child is usually the identified patient in a dysfunctional family.

By contrast, respondents holding a second belief set agree with statements attributing causality to parents, disagree with open information sharing, disagree that medication is helpful or necessary, and disagree with statements validating parents. These respondents agree strongly that the child with an emotional or behavioral disturbance is the identified patient in a dysfunctional family and that parents' ideas are important mostly to give the worker clues about family dynamics. They agree that they seldom need to refer families of these children to another discipline, and disagree that family dysfunction is often a reaction to a child's biologically based difficult behaviors. These contrasting profiles of *worker self-reported beliefs* are similar to *parental perceptions of worker beliefs and attitudes* as reported in the profiles of "best" and "worst" workers (Johnson et al., 1995).

The first pattern of correlations forms a profile congruent with a parent empowerment approach, the second forms a profile antithetical to parent empowerment. These two profiles are derived from the data—but how many respondents actually fit the second profile? Are there a sufficient number to cause concern?

Relatively few NASW general members disagreed unequivocally with open information sharing or with validating statements. Only 12 respondents (2.9%) mostly disagreed with sharing information openly with parents, and only 21 (5.9%) mostly disagreed with validating beliefs. With respect to the belief that professionals should give parents explicit instructions about how to help their child, four-fifths agreed ($n = 336$, 81.6%) and one-fifth disagreed.

However, 75 respondents (18.6%) scored midway between agreeing and disagreeing with open information sharing, and 90 (23.0%) scored between agree and disagree with respect to holding validating beliefs. When parent empowerment criteria are used to evaluate these responses, the number of respondents ambivalent about open information sharing with parents, and disagreeing or partially disagreeing with validating beliefs, is unacceptably large.

The questions of attributing causality to parents for their children's emotional and behavioral disabilities, and beliefs about the helpfulness of medication, were problematic for even larger numbers of respondents. Mean score on attribution of blame was 2.76, between agree and disagree tending toward disagree ($n = 390$). Eighty respondents mostly agreed that parents cause their children's emotional and behavioral disabilities (20.5%), and another 77 (19.8%) partially agreed. The remaining 60% mostly disagreed that parents are culpable.

Mean score for the scale stating that medication is often helpful and/or necessary for children with psychiatric disorders was 2.36, midway between agree and disagree but tending toward agreement. One-third of respondents agreed ($n = 147$, 36.8%), almost one-fifth disagreed ($n = 68$, 17.0%), and 185 respondents scored between agree and disagree (46.2%).

On average, NASW members mostly agreed that the child is the identified patient in a dysfunctional family (agree $n = 297$, 72.8%, disagree $n = 111$, 27.2%) and that parents' views are important mostly to give the worker clues about family dynamics (agree $n = 271$, 66.9%, disagree $n = 134$, 33.1%).

Table 3. *Correlations Between Belief Factors and Individual Questionnaire Items*

Individual questionnaire items		Child is identified patient in dysfunctional family	Parent ideas important mostly as clues to family dynamics	I seldom need to refer families to other disciplines	Workers need research knowledge	Medical journals a good source of info about child/ adolesc. problems	Family dysfunction often reactive to child's bio-based difficult behaviors
Belief Factor							
Attributes cause to parents	*r*	.417***	.236***	.159***	-.014	-.109*	-.173***
(*Blame*)	*n*	386	384	379	390	374	383
Agrees should share info	*r*	.008	.058	-.138**	.212***	.195***	.157**
openly with parents (*Inform*)	*n*	395	395	389	402	386	393
Holds validating views about	*r*	-.100*	-.175***	-.066	.126*	.061	.186***
parents (*Validate*)	*n*	385	385	379	391	378	385
Sees meds as often helpful	*r*	-.063	-.206***	-.212***	.139**	.101*	.178***
(*Medicate*)	*n*	399	395	394	404	389	397
Agrees workers should	*r*	-.065	.122*	-.109*	.144**	.042	.078
explicitly tell parents how	*n*	404	400	398	411	393	401
they can help child (*Instruct*)							

*$p < .05$ **$p < .01$ ***$p < .001$

Five Belief Factors

BLAME: Children's problems are due to parenting deficits (harmful family dynamics, parenting behavior, pathological parenting, poor parenting skills, parents' emotional dysfunction).

INFORM: Information should be shared openly with parents.

VALIDATE: Parents are experts about their own child, are credible reporters, are doing their best for their child, can often teach professionals how to help them and their child.

MEDICATE: Psychotropic medication is often helpful for children and adolescents with emotional and behavioral disabilities.

INSTRUCT: Professionals should give parents explicit instructions about how they can help their children.

Comparison with views of clinical social workers. Table 1 compares the views of the NASW general member sample with those of the clinical social worker sample drawn from NASW's Register of Clinical Social Workers (NASW, 1993; Johnson et al., 1998). NASW general members on average disagreed more with statements blaming parents for their children's problems than did clinical social workers, and were more likely than clinical social workers to view psychotropic medications as helpful for children and adolescents.

On average, both groups agreed with statements expressing validating attitudes toward parents and giving explicit instructions to parents about how they can help their children. For both these variables, a minority disagreed or partially disagreed. General members and clinical social workers did not differ on these two variables. Modest differences between the two groups were found with respect to sharing information openly with parents, with general members more in agreement with open information sharing than clinical social workers. On individual items, both groups agreed that research-based knowledge is important and tended to disagree that they rarely needed to refer families of children with emotional and behavioral disturbance to other disciplines (views consistent with the parent empowerment perspective). However, both groups mostly agreed that parents' views are useful primarily to get clues about family dynamics (antithetical to the parent empowerment perspective). NASW general members mostly agreed, whereas clinical social workers agreed unequivocally, that the child is the identified patient in a dysfunctional family (antithetical to the parent empowerment perspective). NASW general members agreed more (consistent with the parent empowerment perspective) than clinical social workers that family dysfunction is often a response to a child's biologically based difficult behavior.

Overall, general members were less likely than clinical social workers to attribute causality to parents, were more in favor of psychotropic medication for children and adolescents, were somewhat more in favor of open information sharing with parents, agreed less that children with emotional and behavioral disturbance are identified patients in dysfunctional families, and agreed somewhat more that family dysfunction is often a response to a child's biologically based difficult behavior. That is, NASW general members reported beliefs more congruent with a parent empowerment perspective than did their clinical social work counterparts.

Social workers in private practice. Space precludes tabulating the views of private practitioners, but they are important enough to require mention. Private practitioners agreed significantly more with attribution of blame, less that medication is helpful, much more that the child is the identified patient in a dysfunctional family, more that they seldom need to refer families to other disciplines, and less that workers need current research-based knowledge. The scores of private practitioners within the general sample are similar to those reported by the clinical social worker sample. When private practitioners are removed from the general NASW sample, scores of the sample change in the direction of being much more parent empowering. The survey instrument did not ask respondents whether they designated themselves as "clinical," therefore it was not possible to determine the actual overlap between private practice and designating oneself as "clinical."

Influence of demographic variables on social workers' beliefs about parents. Results of multiple regression of demographic variables on belief scales and individual items are reported in another article (authors, in progress). Space precludes inclusion here, except for the following brief summary. The variables most associated with parent empowering beliefs are familiarity with parent support groups, holding a cognitive–behavioral or neuropsychological orientation, and being a general member of NASW rather than a clinical social worker. Differences by professionals' ethnicity and gender, and by the type of client population they served, ranged from small to negligible. Hypotheses about reasons for these findings are presented elsewhere. Data not shown in this article are available from the senior author.

Discussion

The results have shown that beliefs consistent with a parent empowerment perspective are held by a majority of respondents in a national random sample of NASW members, except with respect to a few questionnaire items. A substantial minority of respondents, however, reported views that run mostly counter to the parent empowerment perspective. With respect to two belief factors (open information sharing and holding validating beliefs), about one-fifth of respondents showed ambivalence or partial disagreement. One-fifth of respondents mostly agreed that parents cause their children's emotional and behavioral disorders, and another one-fifth partially agreed. That is, approximately 40% partly or mostly felt that parents are responsible for these disorders. Lack of a parent-friendly perspective among two-fifths of general NASW members was also suggested by disagreeing that family dysfunction is often a reaction to a child's biologically based difficult behavior.

The majority of NASW general members expressed views not congruent with a parent empowerment perspective on one belief factor and two individual belief statements. About two-thirds of the general member sample either disagreed or partially disagreed that medication is often necessary or helpful for children with psychiatric disabilities ("Medicate" factor). Two-thirds of general social workers agreed with two individual items expressing beliefs antithetical to the parent empowerment perspective: that the child is the identified patient in a dysfunctional family, and that parents' views are important mostly to give the worker clues about family dynamics. These views seem to suggest that family

dysfunction is really the cause of children's problems, and that parents' views are not credible or valid in their own right but useful mostly as "clues" to assist workers in ferreting out pathogenic family dynamics. Not only do these views seem to assume parental pathology, but they also appear to cast professionals in the roles of arbiters and detectives-a far cry from the respectful collaborative posture advocated by the parent empowerment perspective. These views were endorsed even more strongly by clinical social workers.

Readers might question the stance of the parent empowerment perspective as judgmental toward practitioners. The perspective does indeed approve of certain beliefs, attitudes, and behaviors, and disapprove of others. However, in this regard it is no different from professional judgments about attitudes and behaviors pertaining to respect and discrimination. It has long been acknowledged that parents of children with emotional and behavioral disorders have been targets of prejudice, similar to people with differences (for example) in ethnicity, sexual orientation, or ablement (Knitzer, 1982). The perspective's normative posture derives from the profession's code of ethics, which judges social workers according to a set of principles of desirable versus undesirable behavior.

The parent empowerment perspective is based on the amalgam of consumer perspectives reported in literature of the last 2 decades, with scientific evidence, also from the last 2 decades. Voices of families of children and adolescents with emotional and behavioral disorders converge with data from the mental health research establishment in challenging conventional practice beliefs dating from the 60s and 70s. Despite the fact that NASW general members agree or strongly agree that current research-based knowledge is important for work with children with mental health issues (mean score 1.64, n = 423), a substantial number of participants gave responses to these items that indicate either ignorance about current research, or, if they are cognizant of it, express views discounting it (Mental Health: A Report by the Surgeon General, 1999; Kagan, 1994; Werner, 1989; Aronson, 1999). NASW has recently applauded the Surgeon General's report on mental health. "The report sets out to alter the widespread misconception that mental illness and physical illness are separate. Mental illness stems from physical causes in the brain ... so there is no real split between 'mental' health and 'physical' health" (O'Neill, 2000, p. 1).

Does this assertion imply that all psychiatric disorders are caused by biology, not environment? The question "But what about abuse?" is invariably raised as a challenge, and the *DSM* diagnosis of posttraumatic stress disorder by definition follows experiences of trauma. Clearly the answer goes back to the repudiation of the biology/environment dichotomy. Prevailing current evidence indicates that symptoms of psychiatric disorders appear as outward manifestations of the interactions of biological and environmental risk factors and protective factors over time. Studies of the effects of physical abuse, sexual abuse, and egregious neglect (the most extreme forms of poor parenting), when continued for many years during childhood, do appear to lead to emotional and cognitive damage in vulnerable children (Lewis, 1992). Similarly, recent neuroscience research suggests that characteristics loosely referred to as "attachment disorder" may arise in a specific area of the brain (a part of the temporal lobe) thought to mediate ability to relate to others, characteristics traceable to institutional rearing in situations where opportunities for tactile and vocal stimulation and eye contact with caretakers were severely limited (Chugani, in Talbot, 1998).

Thus the notion that symptoms of psychiatric disorders arise directly from phenomena in the organ called the brain does not contravene the belief that abuse can cause psychological damage. It asserts that observable "symptoms" of psychological damage arise from differences in brain functions and/or structures from the "typical" or "normal", and that these differences can be created mostly by biological factors, such as genetics, viral illness, anoxia at birth (with added risk factors from the environment); mostly by environmental factors, such as combat experience or child maltreatment (with the added risk factor of biological vulnerability); or by interactions between the two involving major contributions from both—for example, the combination of biological vulnerability and an invalidating environment in borderline personality disorder (Mental Health: A Report by the Surgeon General, 1999; Shearin & Linehan, 1993).

The parent empowerment perspective does not require denying that parents may play roles in contributing to children's problems. It does entail understanding such roles as amenable to learning (for example, through training coping skills), as responsive to environmental supports (financial assistance, respite care, special education), and as seldom causative of psychiatric disabilities. In praising the Surgeon General's report, NASW goes on to say: "A challenge in the near term is to speed transfer of *new evidence-based treatments and prevention interventions* into diverse service delivery settings and systems" (O'Neill, 2000, p. 6; emphasis added). The new evidence-based treatments encompass a parent empowerment perspective by service providers and point to the need for replacement of older paradigms of practice whose vestiges have been documented in this study.

Implications for Practice

Barbara Friesen has summarized changes in theoretical perspectives, practice roles, and service delivery mechanisms that are required to translate a parent empowerment perspective into practice (Friesen, 1993, p. 13). These changes in the view of the authors should also be reflected as content in social work education.

Changes in Theoretical Perspectives

- From psychological models focusing mostly on intra- and interpersonal phenomena to more complex biopsychosocial and ecological models
- From a focus on "child saving" to a focus on preserving and supporting families
- From a primary view of families as objects of intervention (clients, patients) to families as partners in the design, delivery, and evaluation of services

Expanded Concepts of Service Delivery and Practice Roles

- From a paradigm of program-centered services, with emphasis on eligibility and appropriateness of referrals, to child- and family-centered services that are individualized and flexible, where the emphasis is placed on the needs, values, and preferences of families and respect for their cultural backgrounds
- From a solely therapeutic focus on the child's behavior, emotional life, and family dynamics, to comprehensive services that address the full range of the child's needs (e.g., health, mental health, education, recreation, etc.)
- From an exclusive focus on formal services to recognition of informal supports such as extended family, friends, neighbors, churches, social clubs, and others
- From agency-based "expert" professional roles to professionals who work collaboratively with families, in settings of the families' choice, sharing information, responsibility, and power
- From interdisciplinary team functioning to collaboration with family members as full members of the team
- From a specialized, fragmented set of services to an emphasis on coordination at the interagency and case level
- From limited service options, consisting mostly of outpatient, residential, or inpatient services, to a wide array of services including day treatment, in-home intervention, family support, therapeutic foster care, supported education, recreation, and after school activities, among others—a system that puts most resources into flexible, community-based alternatives and flexible funds

Such changes have taken place in some areas of the country, at least in part. In many other areas, much work is still needed. The parent empowerment perspective contributes a rationale for and an impetus to some of these advances in practice with parents of children and adolescents with emotional and behavioral disabilities.

References

Aronson, E. (1999). *The social animal* (8th ed.). New York: Worth/Freeman.

Biegel, D. E., Song, L. Y., & Milligan, S. E. (1995). A comparative analysis of family caregivers' perceived relationships with mental health professionals. *Psychiatric Services, 46*(5), 477–482.

Bouchard T. J., Jr., & Hur, Y. M. (1998). Genetic and environmental influences on the continuous scales of the Myers-Briggs Type Indicator: An analysis based on twins reared apart. *Journal of Personality 66*(2), 135–49.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge: Harvard University Press.

Callahan, M., & Lumb, C. (1995). My cheque and my children: The long road to empowerment in child welfare. *Child Welfare, 74*(3), 795–819.

Carlson, R. W. (1985). Connecting clinical information processing with computer support. *Computers in Human Services, 1*(1), 51–66.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*(1), 155–159.

Cohen, J. (1994). The earth is round ($p < .05$). *American Psychologist, 49*(12), 997–1003.

Duchnowski, A. J., Johnson, M. K., Hall, K. S., Kutash, K., & Friedman, R. M. (1993). The alternatives to residential treatment study: Initial findings. *Journal of Emotional and Behavioral Disorders 1*(1), 17–26.

Dulcan, M. K., & Martini, D. R. (1999). *Concise guide to child and adolescent psychiatry* (2nd ed.). Washington, DC: American Psychiatric Press.

Early, T. J., & GlenMaye, L. F. (2000). Valuing families: Social work practice with families from a strengths perspective. *Social Work, 45*(2), 118–130.

Elder, G. H. (1974). *Children of the Great Depression*. Chicago: University of Chicago Press.

Fisher, G. A. (1998). *Replication of the providers' beliefs about parents questionnaire*. Amherst, MA. University of Massaschusetts. Unpublished.

Friesen, B. J. (1993). Overview: Advances in child mental health. In H. C. Johnson (Ed.), *Child mental health in the 1990s* (pp. 12–16). Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Friesen, B. J. (1989). *Survey of parents whose children have serious emotional disorders: Report of a national survey*. Portland State University Research and Training Center, under grant to Families as Allies Project funded by the National Institute on Disability and Rehabilitation, U.S. Department of Education, and the National Institute of Mental Health.

Gibelman, M., & Schervish, P. H. (1997). *Who we are: A second look*. Washington: NASW Press.

Goldstein, H. (1990). Strengths or pathology: Ethical and rhetorical contrasts in approaches to practice. *Families in Society, 71*, 267–276.

Hara, S., & Ooms, T. (1995, November). *Children's mental health services: Policy implications of the new paradigm*, Family Impact Seminar, Washington, DC.

Johnson, H. C. (1980). *Behavior, psychopathology, and the brain*. New York: Curriculum Concepts.

Johnson, H. C., Cournoyer, D. E., & Bond, B. M. (1995). Professional ethics and parents as consumers: How well are we doing? *Families in Society, 76*(7), 408–420.

Johnson, H. C., Cournoyer, D. E., & Fisher, G. A. (1994). Measuring worker cognitions about parents of children with mental and emotional disabilities. *Journal of Emotional and Behavioral Disorders, 2*(2), 99–108.

Johnson, H. C., Cournoyer, D. E., Fisher, G. A., McQuillan, B., Moriarty, R. A., Stanek, E. J., Stockford, C., & Yirigian, B. (2000). Children's emotional and behavioral disabilities: Attributions of parent responsibility by professionals. *American Journal of Orthopsychiatry, 70*(3), 327–339.

Johnson, H. C., Renaud, E., Schmidt, D. T., & Stanek, E. J. (1998). Social workers' views of parents of children with mental and emotional disabilities. *Families in Society, 79*(3), 173–187.

Johnson, H. C., & Renaud, E. (1997). Professional beliefs about parents of children with mental and emotional disabilities: A cross-discipline comparison. *Journal of Emotional and Behavioral Disorders, 5*, 149–161.

Kagan, J. (1994). *The nature of the child* (10th ann. ed). New York: Basic Books.

Kagan, J., & Zentner, M. (1996). Early childhood predictors of adult psychopathology. *Harvard Review of Psychiatry, 3*, 341–50.

Kelley, H. H. (1967). Attribution theory in social psychology. *Nebraska Symposium on Motivation, 14*, 192–238.

Kim, J. O., & Mueller, C. W. (1978). *Introduction to factor analysis*. Newbury Park, CA: Sage.

Kleinbaum, D. G., Kupper, L. L., & Muller, K. E. (1988). *Applied regression analysis and other multivariable methods* (2nd ed.). Boston: PWS-Kent.

Knitzer, J. (1982). *Unclaimed children*. Washington, DC: Children's Defense Fund.

Lewis, D. O. (1992). From abuse to violence: psychophysiological consequences of maltreatment. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*(3), 383–391.

Lewis, D. O., & Balla, D. A. (1976). *Delinquency and psychopathology.* New York: Grune & Stratton.

Mental health: A report by the surgeon general. (1999). U.S. Public Health Service. Retrieved from http://www.surgeongeneral.gov/library/reports.htm.

Merriam-Webster. (1988). *Webster's ninth new collegiate dictionary.* Springfield, MA: Author.

Miller, J. G. (1978). *Living Systems.* New York: McGraw-Hill.

Mohr, W. K. (2000). Rethinking professional attitudes in mental health settings. *Qualitative Health Research, 10*(5), 595–611.

National Association of Social Workers. (1995). *Code of ethics.* Washington DC: Author.

National Association of Social Workers. (1993). *Register of Clinical Social Workers* (7th ed.). Washington DC: Author.

National Child Welfare Resource Center for Family-Centered Practice. (2000). Can we put clothes on this emperor? *Best Practice, Next Practice, 1*(1), 7–11.

O'Neill, J. V. (2000). Surgeon General's report lauded. *NASW News, 45*(2), 1, 6.

Peschel, E., Peschel, R., Howe, C., & Howe, J. (Eds.). (1992). *Neurobiological disorders in children and adolescents.* San Francisco: Jossey-Bass.

Petr, C. G., & Allen, R. I. (1997). Family-centered professional behavior: Frequency and importance to parents. *Journal of Emotional and Behavioral Disorders, 5*(4), 196–204.

Rubin, A., Cardenas, J., Warren, K., Pike, C. K., & Wambach, K. (1998). Outdated practitioner views about family culpability and severe mental disorders. *Social Work, 43*(5), 412–422.

Saleebey, D. (Ed.). (1996). *The strengths perspective in social work practice* (2nd ed.). New York: Longman.

Shearin, E. N., & Linehan, M. M. (1994). Dialectical behavior therapy for borderline personality disorder: Theoretical and empirical foundations. *Acta Psychiatrica Scandinavica, 89*(suppl. 379), 61–68.

Stroul, B. A., & Friedman, R. M. (1994). Introduction. *Progress in children's mental health: A system of care for children and youth* (pp. iii–xii). Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Talbot, M. (1998, May 24). Attachment: The ultimate experiment. *The New York Times Magazine,* pp. 24–54.

Waslick, B., & Greenhill, L. (1997). Attention-deficit hyperactivity disorder. In J. M. Wiener (Ed.), *Textbook of child and adolescent psychiatry* (2nd ed.) (pp. 389–410). Washington, DC: American Psychiatric Press.

Weick, A., Rapp, C., Sullivan, W. P., & Kisthardt, W. (1989). A strengths perspective for social work practice. *Social Work,* 34, 350–354.

Werner, E. E. (1989). Children of the garden island. *Scientific American, 260*(4), 350–354.

Harriette C. Johnson, MSW, PhD, *is professor and chair, Mental Health and Substance Abuse, and chair, Human Behavior in the Social Environment Committee, School of Social Work, University of Connecticut, West Hartford, CT;* ***David E Cournoyer, PhD,*** *is associate dean of administration, School of Social Work, University of Connecticut;* ***June Fliri, MSW,*** *is a business consultant, Mystic, CT;* ***Miriam Flynn, MSW,*** *is a clinician, Susan B. Anthony Center, Lauderdale Lakes, FL;* ***Andrea M Grant, MSW,*** *is a clinical social worker, University of Connecticut Health Center, Hartford;* ***Maryanne A. Lant, MSW,*** *is an intensive family preservation therapist, Klingberg Family Centers, Hartford;* ***Spero Parasco, MSW,*** *is a caseworker, Families in Crisis, Hartford; and* ***Edward J. Stanek, Ph.D,*** *is professor of biostatistics, department of Biostatistics and Epidemology, School of Public Health & Health Sciences, University of Massachusetts, Amherst, MA. Correspondence can be addressed to Professor Johnson at the University of Connecticut School of Social Work, 1798 Asylum Avenue, West Hartford, CT 06117. Her e-mail address is hcjohnson@attbi.com.*

Submitted: November 2000
Revised: October, 2001
Accepted: April 2002

Table A1. *Demographic Information: Sample of General NASW Members*

Gender	***n***	**%**
Male	120	30.5
Female	274	69.5
Total	394	100.0
Ethnicity	***n***	**%**
African American	31	7.4
Asian	12	2.9
Latino/a	5	1.2
White	368	87.8
Other	3	.7
Total	419	100.0
Practice Settings	***n***	
School social work	44	
Health care	54	
Adult mental health	114	
Child mental health	85	
Substance abuse	33	
Family and children's services	63	
Aging	23	
Criminal justice	11	
Residential treatment	7	
Private practice	114	
Other setting	86	
Total	634[a]	
Geographic Location	***n***	**%**
Northeast	56	13.5
South	104	25.1
Midwest	37	8.9
Southwest	52	12.6
West Coast	164	39.6
Other	1	.2
Total	414	99.9[b]

[a] Adds up to more than total sample because respondents were asked to circle all that apply.

[b] Discrepancy due to rounding error.