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The relationship between different models of family level interventions and two components of practitioner helpgiving (relational practices and participatory practices) was examined in two studies of parents of young children involved in different kinds of family oriented helpgiving programs. Relational and participatory aspects of helpgiving were found to be practiced less often in professionally centered programs compared to other kinds of family oriented programs. Participatory helpgiving practices that provided parents with (a) choices and options and (b) opportunities to be involved in both solutions to problems and acquisition of knowledge and skills that strengthen functioning were more likely to be found in programs that were family centered. Findings are discussed in terms of the importance of the models used to structure social and human services program practices.

Family-oriented approaches in social work, human services, and related fields are grounded in different conceptual and theoretical models that guide the ways in which interventions are conceptualized and implemented (e.g., Adams & Nelson, 1995; Boss, Doherty, LaRossa, Schumm, & Steinmetz, 1993; Griffin & Greene, 1999; Pare, 1995). In the time since Hartman and Laird (1983) called for adoption of family centered social work practice, there has been burgeoning interest in operationalizing different family oriented models (e.g., Desai, 1997; Jung, 1996; Keith, 1995; McCroskey & Meezan, 1998; Nelson, Landsman, & Deutelbaum, 1990), and in developing measurement procedures that distinguish between similar but different intervention paradigms (Booth & Cottone, 2000; Doherty, 1995; Dunst, in press).

Program models in social and human services interventions guide not only how practitioners view the locus of and solutions to family problems, but also the roles that practitioners play in helping families improve their lives. For example, Laird (1995) described the kinds of practitioner behavior most associated with a family centered paradigm and articulated methods for discerning adherence to this approach to working with families (see also Adams & Nelson, 1995; Briar-Lawson, 1998). Similarly, Powell (1996) delineated six stages (roles) that practitioners play in implementing family centered practice, beginning with partnering with families and ending with joint reflection on achievements.

The assertion that particular family oriented models engender different practitioner roles and behavior would lead one to expect that adoption of different models would be associated with different kinds of helpgiving practices. The purpose of the studies described here was to ascertain whether two components of helpgiving were differentially related to the type of family oriented program model used by different social or human services programs and agencies. Corroborating evidence from various studies on the relationships between contrasting intervention approaches and helping styles provides support for the hypothesis that adoption of particular kinds of family oriented models

would predict differences in the help giver behavior of staff in these programs (e.g., Brickman et al., 1983; Karuza, Rabinowitz, & Zevon, 1986; van Ryn & Heaney, 1997).

As part of research and practice in early childhood intervention and family support, Dunst, Johanson, Trivette, and Hamby (1991) developed a framework for differentiating between four family oriented models to interventions that are based on assumptions about family member capabilities and the roles that helpgiving professionals and help receivers play in promoting changes in family development and functioning. Within this framework, different ways of working with families are aligned along a continuum of four family oriented program models (professionally centered, family allied, family focused, and family centered), where each model is characterized by different assumptions and beliefs about families. These assumptions and beliefs, in turn, influence the roles that professionals and family members play in the intervention process. Similar frameworks can be found in Cunningham and Davis (1985), Hornby (1995), and Nelson et al. (1990).

Family Oriented Models

Proponents of professionally centered models view professionals as experts on most matters concerning child and family problems and little or no credence is given to families' views and opinions. This is the case because families are seen as less capable than professionals of knowing what is in their children's and family's best interest and in making decisions and choices about courses of action that should be taken to improve functioning. Therefore, decisions about interventions are made by professionals, and family members are, in most cases, only informed about what professionals deem best and appropriate. The characteristics of a professionally centered model are similar to those described by Brickman et al. (1982) as the defining characteristics of the medical helpgiving model, by Swift (1984; Swift & Levin, 1987) as the operational features of a paternalistic model to solving people's problems, and by Michlitsch and Frankel (1989) as the major characteristics of an expert-based model of helpgiving.

Advocates of family allied models view professionals as experts and families as the agents of professionals who are enlisted to implement interventions that professionals deem to be important and necessary to improve child and family functioning. Families are viewed as capable to the extent that they follow professional recommendations and prescriptions implemented under the guidance and tutelage of professionals. In this model, families are seen as needing professional assistance and advice

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to acquire capabilities and to effectively influence family behavior and development. Family allied models are described as family guided models in the early childhood education field (Slentz & Bricker, 1992) and as direct guidance models in the helpgiving field (Michlitsch & Frankel, 1989).

In the family focused model, families are seen as capable of making choices and decisions but options are generally limited to what professionals consider the resources, supports, and services needed to improve family functioning. Once choices are made, professionals assume responsibility for providing families with guidance, assistance, and advice about how interventions should be implemented and conducted. The terms family directed and consumer directed (Able-Boone, Goodwin, Sandall, Gordon, & Martin, 1992; Cunningham & Davis, 1985; Hornby, 1995) characterize this way of working with families.

Proponents of family centered models view professionals as partners with and agents of families and they see families as being capable of making informed choices and decisions and acting on their choices in ways that support and strengthen family capabilities to improve family functioning. In this model, the balance of power in family–professional relationships shifts toward the family, as its members' existing capabilities are strengthened and new competencies are learned and the family is able to mobilize desired resources and supports on behalf of its members. The characteristics of a family centered model are similar to those described by Brickman et al. (1982) as the key features of a compensatory model of helpgiving and by Michlitsch and Frankel (1989) and Rappaport (1981, 1987) as the operational characteristics of an empowerment model.

The Dunst et al. (1991) framework, or contrasting models within the framework (e.g., professionally centered vs. family centered), has been the focus of a number of studies categorizing human services, education, and health care programs and practices (e.g., Able-Boone, 1993; Dunst, in press; McBride, Brotherson, Joanning, Whiddon, & Demmitt, 1993) and identifying the features and elements most associated with each family oriented model (e.g., Dunst, Trivette, Starnes, Hamby, & Gordon, 1993). For example, McBride et al. used the multimodel framework to investigate similarities and differences in professional and parent judgments about early intervention program philosophy and practices and they found that different program practices were aligned with the four models in an expected manner. Comparing and contrasting the models that guide the implementation of family support program practices, Dunst et al. (1993) found that programs differed considerably in their paradigmatic underpinnings, ranging along a continuum from professionally centered to family centered.

Family-Oriented Models and Helpgiving Practices

Because the defining characteristics of the different family oriented models overlap with the features of particular kinds of helpgiving models, one would expect that the helpgiving behaviors and styles of staff members who work in different family oriented programs would differ from one program to another. Therefore, we hypothesized that helpgivers in programs that adopt models aligned toward the family centered end of the family oriented continuum would be judged as using more empowering helping behavior and styles compared to the staff in other kinds of programs. This prediction is based on theory and research that indicate a relationship between competency-enhancing conceptualizations of interventions and the kinds of practitioner behavior necessary to produce competency-enhancing effects (Dunst, Trivette, & Thompson, 1990; Elizur, 1996; Gutierrez, DeLois, & GlenMaye, 1995; Rappaport, 1981; van Ryn & Heaney, 1997).

More specifically, we assessed the relationship between the family oriented models used by different helpgiving programs and two components of practitioner helpgiving: relational practices and participatory practices. Relational practices are typically associated with good clinical practice (e.g., Brammer, 1993; Combs & Gonzales, 1994), including active and reflective listening, empathy, warmth, trustworthiness, etc. Participatory practices emphasize helpseeker responsibility for finding solutions to their problems and for acquiring knowledge and skills to improve life circumstances (Maple, 1977; Northouse, 1997; Rappaport, 1987), including helpseeker choice and decision making and active participation in developing and implementing courses of action to achieve desired outcomes. Research indicates that these two components or clusters of helpgiving practices are relatively distinct features of effective helpgiving (Trivette & Dunst, 1998).

Helpgiving Practices and Empowerment

The two kinds of helpgiving practices constituting the focus of investigation here are central features of empowerment theory and practice as described by Gutierrez (1995), McWhirter (1994), Solomon (1976), and others (e.g., Lee, 2000; Lewis, Lewis, Daniels, & D'Andrea, 1998; Mondros & Wilson, 1994; Simon, 1994). Solomon noted that relational helpgiving behaviors (empathy, warmth, genuineness, beliefs about helpseeker capabilities, authenticity, etc.) are the foundations for recognizing and acknowledging people's strengths, and using personal and family assets as a foundation for improving functioning. Participatory helpgiving includes behavior that actively involves people in identifying desired goals and courses of action (Gutierrez et al., 1995; McWhirter, 1991), and which strengthen people's existing capacities and enhance new skills in a deliberate, conscious manner (Gutierrez, 1995). The use of participatory practices in addition to relational practices systematically lessens the helpgiver's involvement in the intervention process so that help-receivers become their own change agents. Research on empowerment processes placing primacy on capacity building strategies indicates that participatory practices have value-added benefits beyond those attributable to the influences of relational practices (Dunst & Trivette, 1996; Gutierrez).

The extent to which differences in helpgiving practices are associated with participation in different kinds of helpgiving programs was assessed in two studies investigating the relationship between family oriented models and relational and participatory helpgiving practices. The first study included parents of young children involved in different helpgiving programs that could be placed at different points along the continuum from professionally centered to family centered. The second study involved parents of young children receiving help from programs that had adopted a family centered model but that exhibited variations in the degree to which adherence to this model had been achieved, as evidenced by differences in parents' judgments about program design and operationalization.

Study 1: Method

Participants

The participants were 214 mothers (97%) and 7 fathers (3%) of children with or at-risk for developmental delays from birth to 6 years of age who were involved in different kinds of family oriented programs in two states (North Carolina and Pennsylvania). The majority of the parents were Caucasian (90%), 9% were African American, and 5% were biracial. Seventy-two percent of the participants were married or living with a partner, and 35% worked outside the home either part- or full-time. Children's participation in the different family oriented programs was attributable to either environmental (e.g., infections) or medical (e.g., prematurity) risk factors or delays in development attributable to known causes (e.g., physical disability).

On average, the study participants were 29.04 years of age ($SD = 7.74$) and had completed 12.62 ($SD = 2.61$) years of school. The participants' families had an average Hollingshead (1975) socioeconomic status (SES) score of 31.37 ($SD = 13.52$) and a gross monthly income of \$1,433 ($SD = 899$) at the time of data collection. The majority of participants (81%) were classified as having low, low-middle, and middle SES backgrounds.

Program Types

Participants were recruited from 22 helpgiving programs (10 in North Carolina and 12 in Pennsylvania) with which we had been working in both research and practice capacities. The programs included early childhood intervention programs ($N = 5$), early childhood–special education programs ($N = 3$), social services departments ($N = 4$), public health departments ($N = 4$), rehabilitative therapy programs ($N = 3$), and health care–medical programs ($N = 3$). All 22 programs purported to be family oriented and focused on parent participation in interventions directed at child behavior and functioning, albeit in different ways. The framework described by Dunst et al. (1991) for categorizing family oriented programs was used to group the programs according to program model along a continuum from those that were professionally centered to those that were family centered.

Four persons (two in North Carolina and two in Pennsylvania), highly familiar with the target organizations, independently rated each program using a 7-point scale varying from 1 = *professionally centered* to 3 = *family allied* to 5 = *family focused* to 7 = *family-centered*. Table 1 shows the criteria used for making the ratings and assigning programs to the different models. Intermediate, noncriterion markers were used to rate programs that were characterized by elements of two adjacent models.

Interrater reliability of the ratings was calculated as the number of agreements divided by the number of agreements plus nonagreements, multiplied by 100. Exact agreements yielded a reliability rating of 81% and 95% agreement for ratings a single point apart. Nine programs were characterized as professionally centered ($M = 1.67$, $SD = .47$), 6 programs were characterized as family allied ($M = 3.50$, $SD = .50$), and 7 programs were characterized as family centered ($M = 6.57$, $SD = .49$). No program was rated as primarily family focused by any of the four judges. Programs receiving a rating of 4 were classified as family allied, and programs receiving a rating of 6 were classified as family centered for purposes of categorizing programs. Professionally centered programs all had ratings of 1 or 2, family

Table 1
Criteria for Assignment of Programs to Family-Oriented Models

Rating	Model	Criteria
1	Professionally centered	Families are seen mostly as deficient and incapable of healthy functioning without professional interventions. Professionals see themselves as experts who determine family needs. Families' views and opinions are given little or no credence. Interventions are implemented by professionals with families being passive participants in the intervention process.
3	Family allied	Families are seen as minimally capable of independently effecting changes in their lives. Families are viewed as agents of professionals for carrying out professionally prescribed recommendations and courses of action. Professionals enlist families to implement intervention under the guidance and tutelage of the professionals.
5	Family focused	Families are seen as capable of making choices among options professionals deem important for healthy functioning. Professionals provide advice and encouragement to families on the basis of their choices and decisions. Interventions focus on monitoring family use of professionally valued services.
7	Family centered	Families are viewed ad fully capable of making informed choices and acting on their choices. Professionals view themselves as agents of families who strengthen existing and promote acquisition of new skills. Interventions emphasize capacity building and resource and support mobilization by families.

allied programs all had ratings of 3 or 4, and family centered programs all had ratings of 6 or 7.

Inspection of the kinds of programs categorized as having different paradigmatic foundations found that the early childhood programs were distributed among all three models, the health care and therapeutic programs were categorized as either professionally centered or family allied, and that two of the social services programs were rated as professionally centered. This was not surprising given the fact that certain types of programs are prone to implicit or explicit use of particular kinds of family oriented models (Bulger & LaPray, 1987; Trivette, Dunst, & Hamby, 1996a).

The extent to which participants in the three different family oriented groups were similar or different was determined by comparative analyses with program model as a grouping variable and seven parent and family background variables (age, education, marital status, work status, ethnicity, income, and SES) as dependent measures. The seven analyses produced only one significant difference. Participants in family centered programs were, on average, 4 years older than participants in the professionally centered or family allied programs, $F(2, 217) = 11.50$, $p < .001$. Ages of the children in the three different family oriented program groupings varied from birth to 6 years of age and did not differ significantly by group.

Procedure

The participants completed the Helpgiving Practices Scale (HPS; Dunst, Trivette, & Hamby, 1996). The HPS includes 25

Table 2
Examples of Relational and Participatory Helpgiving Practices Scale Items

Relational Helpgiving Practices Items				
Professional helpers sometimes differ in whether they *try to understand* a person's concerns by attempting to put themselves in the person's situation. Which rating best describes how [helper] *tries to understand* your concerns?				
1	2	3	4	5
Rarely tries to understand my concerns	Seldom tries to understand my concerns	Sometimes tries to understand my concerns	Generally tries to understand my concerns	Almost always tries to understand my concerns
Professional helpers sometimes differ in how well they *listen* to what people have to say about their situation or desires. Which rating best describes how well [helper] *listens* to you?				
1	2	3	4	5
Rarely listens to what I have to say	Seldom listens to what I have to say	Sometimes listens to what I have to say	Generally listens to what I have to say	Almost always listens to what I have to say
Professional helpers sometimes differ in whether they view people in a *negative or positive light.* Which rating best describes whether [helper] views you in a *negative or positive light?*				
1	2	3	4	5
Almost always views me in a negative light	Sometimes views me in a negative light	Views me neither positively nor negatively	Sometimes views me in a positive light	Almost always views me in a positive light
Professional helpers sometimes differ in whether they focus on people's *strengths or weaknesses.* Which rating best describes whether [helper] focuses on your *strengths or weaknesses?*				
1	2	3	4	5
Almost always focuses on my weaknesses	Sometimes focuses on my weaknesses	Neither focuses on my weaknesses nor my strengths	Sometimes focuses on my strengths	Almost always focuses on my strengths
Participatory Helpgiving Practices Items				
Professional helpers sometimes differ in how much *information* they provide people about the resources and options that are available to them. Which rating best describes how much *information* [helper] gives you about the resources and options that are available to you?				
1	2	3	4	5
Rarely gives me information about resources and options	Seldom gives me information about resources and options	Sometimes gives me information about resources and options	Generally gives me information about resources and options	Almost always gives me information about resources and options
Professional helpers sometimes differ in whether they encourage people to *make their own decisions* about what is in their best interest. Which rating best describes how [helper] encourages you to *make decisions?*				
1	2	3	4	5
Rarely encourages me to make my own decisions	Seldom encourages me to make my own decisions	Sometimes encourages me to make my own decisions	Generally encourages me to make my own decisions	Almost always encourages me to make my own decisions
Professional helpers sometimes differ in how much they encourage people to use their *existing capabilities* and *knowledge* to get resources to meet their needs. Which rating best describes how much [helper] encourages you to use *your capabilities* and *knowledge* to get resources?				
1	2	3	4	5
Rarely encourages me to use my capabilities to get resources	Seldom encourages me to use my capabilities to get resources	Sometimes encourages me to use my capabilities to get resources	Generally encourages me to use my capabilities to get resources	Almost always encourages me to use my capabilities to get resources
Professional helpers sometimes differ in how much they help people *learn new skills* so they can get resources to meet their needs. Which rating best describes how much [helper] works to help you *learn new skills* to get resources to meet your needs?				
1	2	3	4	5
Rarely helps me learn new skills to get resources	Seldom helps me learn new skills to get resources	Sometimes helps me learn new skills to get resources	Generally helps me learn new skills to get resources	Almost always helps me learn new skills to get resources

items that measure a variety of helpgiving behaviors and practices (α = .96). Respondents are asked to indicate whether a target helpgiver displayed the various kinds of behaviors as part of a helping relationship between the help receiver and his or her family. Each item includes 5 responses from which a respondent selects a behavior that best describes a target helpgiver practice (see Table 2). The 5 responses for each item are different and were developed so as to measure a continuum of helpgiving behaviors. (See Dunst et al., 1996, for a complete description of the scale items and administration procedures.)

A principal components factor analysis with varimax rotation was used to establish the factor structure of participants' responses. The analysis produced a two-factor solution, with 12 items having factor loadings exceeding .51 on one factor (range = .51–.84) and 11 items having factor loadings exceeding .48 on the second factor (range = .48–.78). Two items (trustworthiness of the helpgiver and helpgiver support for helpreceiver decisions) loaded the same on both factors (.43 and .41, respectively). The two factors were labeled respectively *participatory helpgiving practices* and *relational helpgiving practices.* Table 2 shows examples of both types of items. The participatory practices factor (α = .93) included helpgiving behaviors that actively
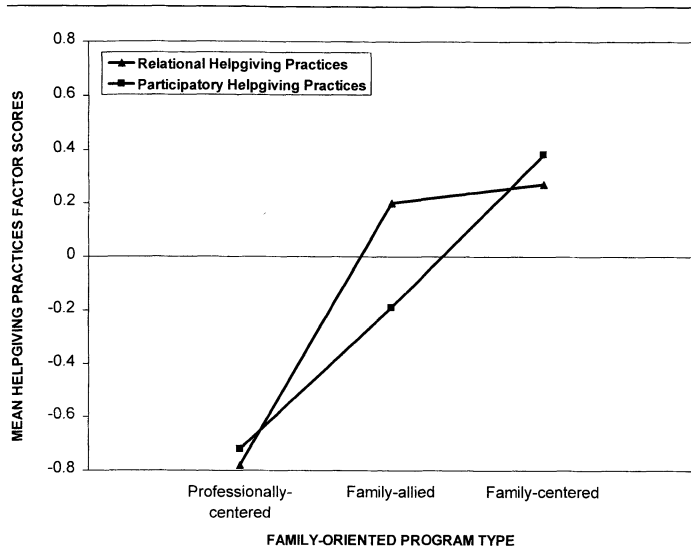
Family Relations

Figure 1. Relationship between different family oriented program types and two kinds of helpgiving practices.

involved helpreceivers in the helping process, including helpreceiver choice and decision making, building upon existing and promoting new helpreceiver competence, helpgiver–helpreceiver collaboration, and the active participation of the helpreceiver in courses of action for attaining desired outcomes. The relational practices factor ($\alpha = .93$) included a combination of behaviors that typically are associated with highly desired clinical practice (active listening, honesty, caring, empathy, etc.) and positive helpreceiver attributions about helpreceiver strengths and capabilities.

The two factor scores were used as the dependent measures of helpgiving practices in the analyses described next. Factor scores were used as the dependent measures for two reasons. First, because "factors are linear combinations of actual variables, factor scores for (individuals) can be perfectly 'estimated'" (Nunnally, 1967, p. 358). Second, because the particular type of factor analysis we performed yielded factor scores that were uncorrelated, the independent contributions of program model on variations in helpgiving practices could be directly assessed.

Data Analysis

A multifactor analysis of variance (ANOVA) was used. Inasmuch as participation in the different family oriented programs was not random, an analysis of covariance (ANCOVA) also was conducted, statistically controlling for the effects of participant age and education and family SES and income before the influence of program model was determined. None of the covariates were significantly related to the dependent measures and the analysis did not change the findings produced by the ANOVA.

Results

A 2 between state (NC vs. PA) X 3 between program type (professionally centered vs. family allied vs. family centered) X 2-level within factor (participatory practices vs. relational practices) ANOVA produced a program type X helpgiving practices interaction, $F(2, 215) = 4.51, p < .05$ (see Figure 1). Tests of simple effects at the different levels of both the program type

and helpgiving practices factors therefore were conducted to ascertain the specific differences between the cell means within the body of the program type X helpgiving practices data matrix (Keppel, 1982).

Inspection of Figure 1 shows that both relational and participatory helpgiving practices were rated poorly in professionally centered (PC) programs; and that both relational and participatory helpgiving practices were rated better in family centered (FC) programs, as evidenced by the patterns of negative and positive mean helpgiving practices factor scores respectively. Relational practices were rated as better than participatory practices in the family allied (FA) programs, $F(1, 215) = 7.53, p < .001$.

Two sets of between type of program simple effects analyses were conducted: one for relational helpgiving and one for participatory helpgiving. Respondents involved in the PC programs assessed helpgivers as displaying fewer relational helpgiving practices compared to the respondents involved in either the FA programs, $F(1, 215) = 28.72, p < .001$, or FC programs, $F(1, 215) = 43.95, p < .0001$. Respondents involved in the FA and FC programs did not differ in terms of their assessments of relational helpgiving. The same comparisons involving participatory practices found significant differences between those in the PC programs compared to those in the FA programs, $F(1, 215) = 9.85, p < .01$, and FC programs, $F(1, 215) = 53.43, p < .001$, and between the respondents' assessment of participatory practices in the FA and the FC programs, $F(1, 215) = 14.69, p < .001$.

Discussion

The findings from Study 1 indicated that the kind of family oriented model used by different helpgiving programs and organizations mattered in terms of helpreceivers' ratings of helpgiver behavior. Helpgivers in professionally centered programs were judged poorly in terms of their use of both relational and participatory practices; helpgivers in family allied programs were judged better in their use of relational compared to participatory practices; and helpgivers in family centered programs were judged good on their use of both relational and participatory practices. The Study 1 findings are consistent with hypotheses about the operational differences between different models of intervention and helpgiving (Brickman et al., 1983; Rappaport, 1981, 1987), and previous research findings indicating that the paradigms implicitly or explicitly used to guide the development and implementation of intervention programs and practices are associated with different helpgiver behaviors and styles (Brickman et al., 1983; Malone, McKinsey, Thyer, & Straka, 2000; Newson & Schultz, 1998; Northouse, 1997; Von Bergen, Soper, Rosenthal, Cox, & Fullerton, 1999). The results extend previous research by demonstrating the differential relationships between program models and two different components of helpgiving practices.

As hypothesized, variations in program model were related to differences in participatory helpgiving practices. This finding deserves special comment in light of research demonstrating that the active participation of helpreceivers in achieving desired outcomes is extremely important for optimizing the empowering benefits of helpgiving (e.g., Judge, 1997; King, King, Rosenbaum, & Goffin, 1999; Trivette, Dunst, & Hamby, 1996a; Trivette, Dunst, & Hamby, 1996b). This suggests that certain family oriented models may be more effective than others, if the outcome of helpgiving is to support and strengthen competence and family problem solving. Research that teases apart and identifies

the independent and combined influences of program models and practitioner helpgiving on these and other outcomes would seem highly indicated (e.g., Dunst, 1999).

Applied studies of the sort reported here often have shortcomings that need to be highlighted. The fact that the kinds of helpgiving programs assigned to the three family oriented models were programmatically different needs to be recognized as a potential factor contributing to the results in addition to variations in paradigmatic foundations (see Trivette, Dunst, & Hamby, 1996a). This potential problem was explicitly addressed in the second study by including only one type of program as the focus of investigation, essentially eliminating variations in program models as a factor influencing study findings.

Study 2: Method

Participants

The participants were 45 mothers of children birth to 3 years of age with or at risk for developmental delays involved in early childhood intervention programs in Pennsylvania. The programs were operated under the auspices of the Pennsylvania Department of Public Welfare as authorized by the Pennsylvania Early Intervention Services System Act (1990). Each participant was involved in a different early childhood program.

The majority of the study participants were Caucasian (93%) and married or living with a partner (77%). Seven percent of the mothers were African American. Just over half (56%) of the mothers worked outside the home either part- or full-time. Children were identified as at-risk for either biological or medical reasons, or delayed in development as determined by developmental assessments of their behavioral functioning.

The mothers were recruited from a larger sample of parents in another study (Dunst, Brookfield, & Epstein, 1998) so: (a) there were an equal number of respondents at each of five levels of family SES (Hollingshead, 1975), and (b) each respondent was involved in a helping relationship with a different target helpgiver. None of the parents in the Study 1 sample were included in Study 2. Recruitment of families from different SES backgrounds was done to insure equal representation along the continuum from very poor to very affluent families. On average, the participants were 35.09 years of age (SD = 9.50) and had completed 13.64 (SD = 2.41) years of school. The participants' families had an average gross monthly income of $2,271 ($SD$ = 1,086) at data collection.

Procedure

Participants completed both the Family-Centered Practices Scale (FCP; Dunst & Trivette, 1998) and a short-form version of the Helpgiving Practices Scale (HPS; Dunst et al., 1996). The former asks respondents to make appraisals about whether a target program is characterized by specific paradigmatic features, whereas the latter asks respondents to make appraisals about the behavior of a target helpgiver with whom he or she has a helping relationship.

The FCP scale includes 10 items that measure different aspects of family centered program practices (α = .89). The kinds of program practices on the FCP scale which measure family centeredness include family participation in program decisions and decisions involving child and family interventions; program flexibility and responsiveness to family concerns and priorities; and program individualization in terms of the sources, location,

and focus of intervention. The items were scored on a 7-point scale varying from 1 = *strongly disagree* to 7 = *strongly agree* (that the practice is characteristic of the program being rated). The sum of ratings was used as the measure of family centeredness. A tripartite split of these scores was used to divide the sample into three groups, experiencing low, median, and high degrees of family centered practices. This tactic was used to construct a grouping variable where differences in group assignments constituted different levels or degrees of family centeredness. The means and standard deviations were 47.79 (SD = 4.22), 58.71 (SD = 2.55), and 67.06 (SD = 1.30) for the low, median, and high family centered groups, respectively.

The extent to which participants in the three different family centered groups were similar or different was determined by comparative analyses with seven background variables (ages, education, ethnicity, marital status, work status, SES, and income) as dependent measures. No analysis produced significant differences between groups on any of the measures. Additionally, there was no difference in the children's ages as a function of group assignment.

The short-form version of the HPS includes 12 items (α = .91) selected from the factor loadings of the full scale (Dunst et al., 1996). The 6 participatory helpgiving and 6 relational helpgiving practices items with the highest factor loadings (Dunst et al.) were selected as the item content. A principal components factor analysis with varimax rotation of the 12-item version of the scale produced a two-factor solution identical to that reported above for the 25-item version of the scale. The 6 participatory practices items had factor loadings between .53 and .89, and the 6 relational practices items had factor loadings between .62 and .97. Both the participatory practices (α = .89) and relational practices (α = .87) factors had alphas indicating adequate internal consistency. The participatory items included practices that used the helpreceivers' existing capabilities and promoted acquisition of new abilities; information sharing so the helpreceiver could make informed choices and decisions; helpreceiver and helpgiver collaboration and planning; and a solution-based approach to achieving desired outcomes. The relational items included helpgiver active listening, honesty, and caring; and a strengths-based and positive stance toward the helpreceiver. The two factor scores were used as the dependent measures of helpgiving practices in the analyses described next.

Data Analysis

Both an ANOVA and ANCOVA were used to analyze the data, with parent age and education and family SES and income as covariates. None of the covariates were significantly related to the dependent measures, and the findings from the ANCOVA were identical to those produced by the ANOVA.

Results

A 3 between levels of family centeredness (low vs. medium vs. high) X 2-level within factor (participatory practices vs. relational practices) ANOVA produced a family-centered group X type of helpgiving practices interaction, $F(2, 42)$ = 4.85, p < .01 (see Figure 2). Tests of simple effects found that respondents experiencing different degrees of family centered practices did not differ in terms of their assessment of relational helpgiving, whereas respondents experiencing practices more consistent with a family centered model assessed helpgiving practices as more participatory compared to respondents experiencing either me-
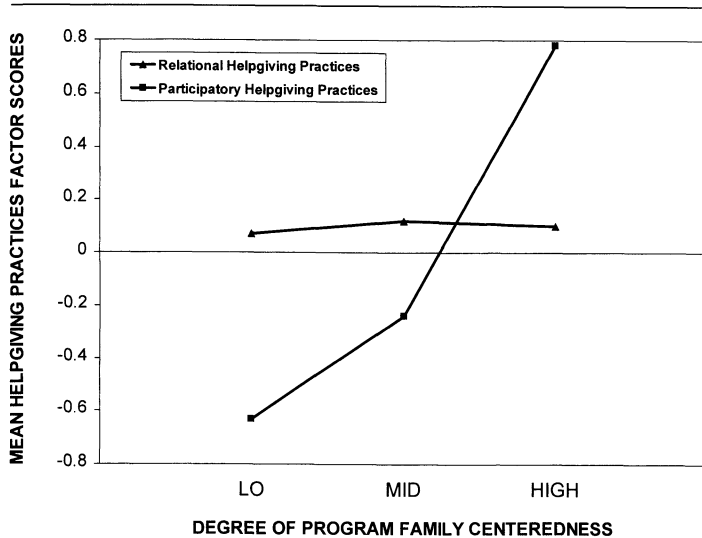
Figure 2. Relationship between the degree of adherence to a family centered approach and two kinds of helpgiving practices.

dium, $F(1, 42) = 10.31, p < .01$, or low, $F(1, 42) = 20.50, p < .0001$, degrees of family centered practices. Respondents experiencing low versus medium degrees of family centeredness did not differ significantly in terms of their assessment of participatory helpgiving practices.

Further tests of simple effects were conducted to ascertain if relational and participatory helpgiving practices were assessed differently at the different levels of family centeredness. Respondents in the low family centered group judged helpgivers as using fewer participatory practices compared to relational practices $F(1, 42) = 4.12, p < .05$. Respondents in the high family centered group judged helpgivers as using more participatory practices compared to relational practices, $F(1, 42) = 4.58, p < .05$. There was no significant difference in the assessment of the two types of helpgiving practices by the respondents in the median family centered group.

Discussion

The findings from Study 2 indicated that participatory helpgiving practices, but not relational helpgiving, varied as a function of the degree of family centeredness of early intervention programs. Results demonstrate that parents involved in programs that are characterized as having features that are family centered (Allen & Petr, 1998; Dunst, 1995, 1997) are more likely to indicate that practitioners employ helpgiving behaviors and styles that promote active helpreceiver participation in different aspects of resource and support mobilization. Research further indicates that the latter is related to improved parent and family functioning (Judge, 1997; King et al., 1999; Thompson et al., 1997; Trivette, Dunst, & Hamby, 1996a, 1996b).

The fact that participatory and not relational helpgiving practices were related to variations in the family centeredness of programs deserves comment in light of contentions made by others regarding the primacy of relational helpgiving as a determinant of effective helpgiving (see Dunst, Trivette, & Snyder, 2000; Roberts, Rule, & Innocenti, 1998, for descriptions of these claims). The first has to do with the assertion that the relational aspects of family–practitioner transactions are what differentiate

family centered models from other types of family oriented programs. The second has to do with the claim that the relational aspects of family–practitioner transactions are what need to be emphasized as part of empowering and competency-enhancing helpgiving skills. Both contentions must be qualified in light of the findings from Studies 1 and 2 and related research (see especially Dunst, in press; Dunst & Trivette, 1996; van Ryn & Heaney, 1997). First, the findings from the studies reported here indicate that both relational and participatory helpgiving practices are what distinguish family centered programs from other family oriented models (Study 1); and that among programs that are family centered, participatory but not relational helpgiving practices differ as a function of variations in the family centeredness of programs (Study 2). Second, studies that have included measures of both relational and participatory helpgiving practices have generally found that there are value-added benefits of participatory practices beyond those attributable to relational practices, at least in terms of certain parent and family outcomes (Judge, 1997; Trivette, Dunst, & Hamby, 1996b; Trivette, Dunst, Hamby, & LaPointe, 1996). Consequently, the importance of participatory helpgiving practices should not be overshadowed by claims about the benefits of good relational practices.

General Discussion

At the outset we noted that different models provide different lenses for structuring human and social services interventions and for understanding how practitioners conceptualize their relationships with families. A framework for differentiating between four family oriented models of intervention was described and used to test the hypothesis that helpgiving practices would differ among practitioners in different types of programs. The findings not only confirmed this expectation but also demonstrated that variations in adherence to basic tenets of a particular model is strongly associated with variations in the participatory aspects, and to a lesser extent the relational aspects, of helpgiving. At least in terms of the helpgiving behaviors and styles constituting the focus of the studies described here, the program models either implicitly or explicitly adopted by helpgiving organizations and agencies mattered a great deal in terms of how professionals were judged by people they were attempting to help.

The focus of the studies described here reflects a contemporary interest in understanding the characteristics and consequences of different models of family level interventions (e.g., Ainsworth, 1998; Doherty, 1995; Keith, 1995; Marsh, 1994). The framework we used constitutes one way of conceptualizing and differentiating between family oriented models and paradigms. Ascertaining the extent to which different program models are related to variations in helpgiving practices is but one aspect of more fully understanding the ecology of human services models and practices and their consequences on helpreceivers. Relating both program paradigm measures and helpgiving styles and practices to variations in family functioning and parenting behavior would further inform both policy and practice with regard to the models and practitioner behavior that would constitute "models of choice" for increasing the likelihood that interventions will have optimal positive benefits. It also would be of interest to know whether different models and helpgiving practices are differentially related to different aspects of family and parent functioning. Studies of the latter sort would provide the kind of evidence-based information needed to make informed

decisions about what models and helpgiving practices ought to be used for achieving specific outcomes and benefits (e.g., Centre for Evidence-Based Social Services, 2002; Gambrill, 1999).

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