The opportunity to deliver a presidential address at the Society of Pediatric Psychology (SPP) annual meeting is a rare one, an honor to be used wisely in the service of our society’s well-being. As a developmentalist, I seize such an opportunity to offer observations on both continuity and change, and an opportunity to consider our history as an element for mapping our future trajectories. Evolution, revolution, and devolution are in a complex harmony as backdrop to these observations. Evolution captures an orderly, sensible progression in our professional development, in our discipline’s emergent young adulthood. Revolution is probably a relevant construct for capturing the political and economic upset and chaos with which we struggle these days; imagery from rebellion and war pervades our experience of the ongoing “reinvention” of the health care delivery systems and processes. Devolution, a more obscure but perhaps more relevant process, involves the return of responsibilities from centralized or federal domains to local or distributed domains. Such reorganizations have impact upon us in what gets termed health care reform, welfare reform, and welfare reform “reform,” and a variety of devolutions from central and federal controls to state and local controls (or lack thereof). The challenges and opportunities inherent in federal regulations can differ dramatically from those associated with block grants to states or community-based programming. Each of these processes—evolution, revolution, and devolution—engages us in reflection upon our values, assumptions, and practices, evident in our discourse and our action (Prilleltensky, 1997).

In asking for your votes in last year’s election, I promised an emphasis on moving SPP forward by building on our solid empirical bases in clinical child psychology and developmental psychopathology. We agreed to move more swiftly and decidedly toward embracing families and colleagues in other health and prevention specialties in a broader, more inclusive context. My comments here are, I hope, part of that movement.

Defining Collaboration

As pediatric psychologists are wont to do, let me begin with just a quick assessment, a “fill-in-the-blank” item just to put us on the same page: “The difficulty with ______________ work in pediatrics is that we all do it, yet very few of us spend much time considering what it is we are doing” (Stabler, 1988, in Hamlett and Stabler, 1995, p. 563). The original text said “consultation-liaison work”—a key progenitor of what we now often refer to as collaboration. For the present discussion, I propose a generic working definition of “collaboration” as “a mutually beneficial, well-defined relationship entered into by two or more [professionals or ] organizations to achieve results they are more likely to achieve together than alone” (Mattessich and Monsey, 1992, p. 39).

Few endeavors or activities are more salient to us
as pediatric psychologists today than collaboration. This salience spans the full range of our commitments in research, practice, training, and policy. Yet, even as observed by Stabler (1988) a decade ago, little time is spent considering what we are doing. There is some evidence that this might be changing; note the headline banner for one of the flagship symposia at the 1997 APA convention: “Strategic Partnerships for Quality Care: Today, Tomorrow and the 21st Century: Collaborative Approaches to Confronting the Growing Impact of Managed Care Cost-Containment in the Health Care Market Place.”

The remarks that follow are part of an effort to spend a bit of time considering what we are doing. I suggest how each of several domains or models of collaboration is reactive and responsive to the current health care revolution, but I also urge a broader, less temporally and substantively limited perspective. I don’t mind sharing my own bias that it is best for us to focus our energy and creativity on “life after managed care.” Further, even if one’s contemporary functioning as a pediatric psychologist might indeed be preoccupied or overwhelmed with “managed care” concerns, adaptation and advancement of pediatric psychology depend on the broader vision that includes our historical and future endeavors, many of which are indeed collaborative in nature.

I have been pondering the questions of how and why it is that such a key or central value, activity, skill, or technique in pediatric psychology—collaboration—could be such an inarticulate, unarticulated concept. Why the “family secret,” “the skeleton in the closet,” “the ghost in the nursery,” “the step-child status?” At the risk of reducing the issues to simple semantics, I’ll share with you some of my more logical or less illogical conjectures.

We all recall the glorious 1960s when our field was born. In 1965 developmental psychologist Jerome Kagan proposed and pronounced the marriage between pediatrics and psychology. Head Start founder and pediatrician Julius Richmond (1967) expounded upon child development as a basic science for pediatrics. By 1967, Logan Wright, soon to become the first president of the Society of Pediatric Psychology, celebrated Kagan’s marriage, welcoming the blessed offspring and articulating collaborative and complementary roles for pediatric psychologists and behavioral and developmental pediatricians.

The marriage metaphor is perhaps as powerful as it is complex. Marriage is very hard work—ask any of us formerly or presently married. Divorce can be even more challenging than marriage. Very recently, the concept and techniques of “Collaborative Divorce” have been expounded by Nurse and Thompson (1997). Fortunately, and proactively, they titled their paper “Collaborative Divorce: Oxymoron or a New Process?” In any event, metaphors of family formation/dissolution, family coping, adaptation, function or dysfunction may help us understand how and why collaboration stays closeted or implicit.

The oxymoronic dimension is also evident in some other definitions, associations, and connotations of “collaboration.” Some is reflected in trade humor. One of my colleagues begins his collaboration workshops with the query, “What are the three most important features or dynamics of successful collaboration?” The answer he skillfully draws from the group is the three key features: “self-interest, self-interest, self-interest” (L. Bailis, personal communication, 1997). Other proponents account for the value of collaboration as a resolution of the “blind men and an elephant fable”; that is, each person examines a different part of the elephant and, sans collaboration, constructs a narrow, fragmented, inaccurate perspective. So, when collaboration becomes an explicit norm, value, or practice, we will all be relieved in not having to hear that old elephant joke anymore.

All joking aside, some deeper identification process may also be at the root of us baby-boomers’ complicated closeting of collaboration. World War II buffs recognize that the conquered peoples of Europe faced a difficult choice—they either joined the “resistance” or they became “collaborators.” More recently, long after the World War and the Cold War, a leader in the collaborative family health field offered this tongue-in-cheek definition of collaboration: “cooperating with the enemy” (McDaniel, in Seaburn, Lorenz, Gunn, Gawinski, & Mauksch, 1996, p 105).

Psychologists are no stranger to the absurd or the oxymoronic. We can recognize understandable concerns about a certain faddishness with “collaboration.” Few of us who spend our energy responding to Requests for Proposals from foundations and government agencies have not complied with the now-typical directives to form partnerships and collaborative teams to design and implement the fundable study or program. Few of us writing budget justifications in our departments
have not encountered, or have even invoked the cost-effectiveness and projected savings we will accomplish through collaboration, knowing full well that usually, at least for the first chunk of time—say 2–3 years—collaboration is actually a very expensive endeavor.

**Recent Advances in Collaboration**

Enough musing on the lingo that closets collaboration. Let me pick on two books that I consider required reading for pediatric psychologists to begin to articulate some of the more substantive dimensions of the problem of collaboration. Then I can offer a proposal that bridges or links these two books, figuratively, at least, or provide some cross-cultural immersion in the service of collaboration, maybe in itself a good goal or solution.

First, I hope and expect most of you are familiar with what I consider one of the most useful and important books in our field appearing in the last 2–3 years: Dennis Drotar’s (1995) *Consulting With Pediatricians*. In collaboration with a number of colleagues, Drotar sketches a fine historical and conceptual framework for this key activity of pediatric psychologists and explores its nuance in and across settings and populations such as primary care, family medicine, chronic illness, inpatient work, and clinical research. What little empirical research exists is summarized and included as a crucial area for further growth. Research on consultation is a rich and needing-to-be-cultivated area to address issues of ethics, training, and professional development. Much of the Drotar book is actually presented as a guide to “collaboration”—15 of the 17 chapters include “collaboration” in their titles; only 6 chapters include “consultation” in the title (a few chapters use both terms).

I trust we all agree on the important connotative and denotative differences between consultation and collaboration, and even if we don’t agree on what the distinctions are, they are distinguishable. Elaboration of this matter can be considered beyond the scope or purview of this paper.

In preparing this paper, I asked Professor Drotar why he chose to call his book “consulting with pediatricians” rather than “collaborating with pediatricians.” He paused and commented, “It’s probably misnamed” (Drotar, personal communication, July 8, 1997). We then joked about whether sending out an erratum notice on a book title was ever done. Suffice it to say that this misnaming of the book probably reflects a transitional developmental stage or process that some of us pediatric psychologists are in, if not our entire field. This shift involves a move away from traditional and even empowering values and approaches to more postmodern and “emancipatory communitarian” values and approaches (Prilleltensky, 1997). As part of this shift we can acknowledge that our historical “C&L” work of consulting to pediatricians has evolved into consulting with them. Now we can be freer and more open about collaborating with them and with allied professionals and with families.

In introducing the book, Drotar laments what he calls “lost collaborative opportunities” (vii). He observes a paradox in that collaboration can be among the most challenging, frustrating and avoided activities. Yet, when pediatric psychologists were surveyed on sources of their work-related satisfaction, collaboration ranked among the top (Drotar, Sturm, Eckerle, & White, 1993). Besides the immense utility of the book for the here-and-now workaday world, I value it for the prediction and prescription Drotar offers and with which I fully agree: “To ensure continued development of the field of pediatric psychology, one can anticipate that future practice, research and training will necessitate even closer interdisciplinary communication and collaboration in an ever-widening range of settings” (p. 2). The other “best read” for me in recent months was *Models of Collaboration: A Guide for Mental Health Professionals Working With Health Care Providers*, a “collaborative endeavor” produced by Seaburn, Lorenz, Gunn, Gawinski, & Mauksch (1996). In the old days I would have referred to this volume as “Seaburn’s book,” or “Seaburn, et. al.”; now, in the spirit of their powerful message, I’ll refer to their team as the “collaborative family health care gang,” or “gang of five.” The gang’s book is noteworthy for its erudite historical and conceptual analysis of collaboration, its highly instructive case examples, and, particularly, for its bold, perceptive openness to personal examples to illustrate key technical and ethical dilemmas basic to our work with medical colleagues and families. The book’s appendices provide a useful guide to the professional network of the Collaborative Family Health Care Coalition (CFHCC), training resources, and a few clinical techniques. I thoroughly enjoyed reading this book, connecting to the gang with repeated experiences along the lines of empathy, sympathy, “ringing of
truth,” “been-there-done-that,” and “we’re in the same boat.” Yet, I was uneasy, disconcerted, and frustrated that only 3 or 4 of their 300 pages addressed issues of children or pediatrics. (I do say that the one example they develop a bit is an especially good one: Schroeder’s Chapel Hill Pediatric Associates [Schroeder, 1979]).

Collaborating to Bridge the Gap

We pediatric psychologists have much to learn from the CFHCC gang. And we have much to offer them. I will call liberally upon their basic “Tenets of Collaboration” as I consider steps toward bridging the gap between us: “(1) an integrative paradigm regarding health and mental health problems, (2) an ecological perspective on the interaction between professionals who collaborate, (3) the treatment of patients and families as partners in care (p. 16).”

Their thematic analysis of collaboration’s mission or destiny is highly consistent with similar analyses by pediatric psychologists, including Drotar’s (1995) group. Their three themes that culminate in these tenets are the challenge of mind/body dualism, the healing power of dyadic and systems orientations, and resolving the debate of “paternalism” versus “empowerment” (p. 26). The CFHCC gang’s assertion that “collaboration can be viewed as the latest adaptation to a changing health care environment” (Seaburn et al., 1996, p. 25) could as easily be a statement from me, Drotar, or any of many pediatric psychologists.

These two great books of the 1990s help set the stage for the statement of the problem this paper asks us to consider together. The problem is improving our understanding of collaboration and using such understanding to build better partnerships on behalf of children and families. One such partnership with significant potential is an integration of pediatric psychology and collaborative family health care.

Several relevant resources specify and elaborate the problem and solutions. First, call upon the important theoretical and empirical work on ecological and family-systems approaches in pediatric psychology (Kazak, Segal-Andrews, & Johnson, 1995). Second, call upon the meta-analyses by colleagues at the Wilder Foundation in Minnesota articulating factors influencing successful collaboration (Mattessich & Monsey, 1992). Third, consider Roberts’s (1994) delineation of successful service delivery models in child mental health. Fourth, draw upon our recent experiences in Massachusetts nurturing a network of over 200 “Community Partnerships for Children,” integrating educational, health, and human services for the state’s young children and their families (Center for Applied Child Development, 1997; Wertlieb, Bailis, & Kapuscik, 1996).

Figure 1 depicts a formulation of the problem as a challenge and opportunity to orchestrate a three-part harmony on behalf of children. On the right side is a depiction of Kazak’s (et al., 1995) socioecological model integrating ecological-developmental theory (Bronfenbrenner, 1979, Bronfenbrenner & Ceci, 1994) and a family systems approach to understanding development and intervention. Its compatibility with stress-and-coping models that are most attractive to some pediatric psychologists (Wallander & Thompson, 1995; Wertlieb, 1993; Wertlieb, Jacobson & Hauser, 1990) accounts for a good deal of its utility and appeal. Its specification of several of the tenets and themes generated by the CFHCC gang noted above suggests its utility for the proposed integration.

On the left of Figure 1, at the top quadrant, is an overly simple rendition of our now traditional work in pediatric psychology, captured in the Drotar (1995) book, Consulting With Pediatricians. Notice the child-centeredness and the relatively tangential link with the family.

In the lower quadrant, I caricature the Gang of Five’s model, having the psychologist and health care provider interact and the child isolated or non-existent. Our move from these two caricatures to the well-rounded comprehensiveness of the socioecological model constitutes our preferred path. In simplest terms, then, a merger of the pediatric psychology orientation and the CFHCC orientation is both required and facilitated by a shared vision and purpose reflected in the socioecological model. The much-needed bridge between family-centered approaches and child-centered approaches can be constructed through such collaboration (Wertlieb, 1993). Shared vision and purpose consistently emerge as key factors in successful collaboration (Mattessich & Monsey, 1992). When it comes to advancing our field of pediatric psychology, the success of our collaborative endeavors will be a cornerstone. This proposed collaboration with the Collaborative Family Health Care Coalition, organizationally or conceptually, can be an element of such progress.

In pursuing such collaboration, and in fulfill-
ment of commitments to socioecological models to guide our work, we have an impressive array of tools and resources at our disposal. Both traditionally and in the new era we are experiencing, the hallmark of pediatric psychology as a research discipline with strong scientist-practitioner values will continue to be our vital strength. It is in research endeavors that some of our most successful collaborations with pediatricians and other health care professionals have been most visible and sustained. One need only scan the authorships in our relevant journals—whether our own *Journal of Pediatric Psychology* or other specialty journals—to see the fruit of these collaborations. Many of the same skills we call on for research collaboration are the tools for this more general integration. And I would certainly agree with the prognostications of Rae and DiGirolamo (1997) that in particular, clinical research that improves interventions in directions consistent with the evolving health economics/managed cost dynamics will be most responsible for our further development as a discipline. We already have some nice examples; in the course of developing and documenting “treatments that work,” family-centered pediatric interventions are looking good (or at least promising). For example, projects such as Delameter, Bubb, Davis, Smith, Schmidt, White, and Santiago’s (1990) family-centered diabetes trials or Stein and Jessop’s (1991) demonstration of family-centered home-based care delivery reflect such progressive approaches.

The conceptual tools are in hand as well. My earlier delineation of the CFHCC gang’s basic tenets of collaboration surely brought to mind any number of our key shared conceptual commitments: biopsychosocial models, ecological systems perspectives, family-centered care principles. Given that communication quality is among the key factors identified as part of successful collaboration (Mattessich & Monsey, 1992), the fact that we as pediatric psychologists and collaborative family health care providers share a language with overlapping dialects should be helpful. Frankly, there are times for me when communication across disciplines is easier than a within-psychology conversation, given variations in shared vocabularies. Among the challenges facing us is the manner in which we will make collaboration a focus of training, explicitly equipping the next generations of pediatric psychologists with better skills for the collaborative activities that will clearly be primary in their professional lives.

The advancement of our field depends on creative and energetic collaboration with other professionals, other organizations, and the families of the children whose health we aim to enhance. The ingredients for effectiveness of our work are being increasingly clarified and articulated. The synergy and
complementarity of effectiveness and collaboration are increasingly apparent. The analysis offered by Roberts's (1994) portrayal of key elements in model services for children is consistent with our findings while nurturing and evaluating community partnerships for children (Center for Applied Child Development, 1997; Wertlieb et al., 1996). For the most part they are the same challenges and opportunities we have for orchestrating the three-part harmony of pediatric psychology and collaborative family health care. The Roberts's (1994) Task Force on Model Service Delivery in Child and Family Mental Health highlighted these interacting features or commonalities:

1. A focus on the ecology of the child;
2. Collaboration for comprehensive, yet versatile services;
3. Clearly defined missions;
4. Reduction of barriers to access;
5. Ability to be replicated and adapted;
6. Demonstrated accountability and effectiveness; and
7. Strong and dynamic leadership (p. 212).

So once again, we know what to do and how to do it (Schorr & Schorr, 1988). May we continue to practice the “seven habits of highly effective collaboration.” May your next collaboration on behalf of a child be even better than your last.

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References


