Once the door closes: Understanding the parent–provider relationship

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Abstract

The parent–provider relationship has been purported to be a central mechanism by which home-based parenting education and family support programs affect child and family outcomes. Despite its centrality in the theory of such programs, we have limited knowledge of how this relationship develops and functions, and how it may influence program outcomes. This article describes three levels of examination that can be used to understand the parent–provider relationship, using the example of one evaluation of a statewide home visiting program for teen parents. By examining the relationship on several levels, we are able to demonstrate its complexity, and to begin to explore its many dimensions. In-depth observational methods provide the most sophisticated understanding of the parent–provider relationship.

Keywords: Parent–provider relationship; Home visiting programs; Social problems

1. Introduction

Home visiting has existed as a strategy for serving families in need for over a century. In the last decade, however, there has been a significant increase in the size and diversity of the population served by home visiting programs. Millions of public and private dollars have been devoted to home visiting programs designed to address a host of social problems, including child abuse and neglect, poor school achievement, externalizing problems in children, and repeat teen pregnancy.

Home visiting programs that serve families with young children attempt to promote positive changes in parents and their children by providing social support, information about parenting and child development, and practical assistance (Gomby, 1999; Gomby, Culross, & Behrman, 1999). The underlying theory of such programs is that parents receiving these types of services will interact with their children in positive ways and will provide safe and stimulating environments for their children (Duggan et al., 2000; Olds, Kitzman, Cole, & Robinson, 1997). Home visiting programs are founded on the belief that one of the best ways to reach families, especially families with young children, is to bring services to them rather than expect families to seek out services in the community (Baker, Piotrkowski, &
Brooks-Gunn, 1999; Gomby, Larson, Lewit, & Behrman, 1993; Wagner & Clayton, 1999). Visiting families in their homes allows providers to serve families with limited access to transportation, assess the context in which the families live and thereby tailor services to specific needs, and involve multiple family members in the intervention (Gomby et al., 1999; Samuels, Stockdale, & Crase, 1994; Wagner & Clayton, 1999). Furthermore, the informal and intimate nature of the home visit is generally believed to foster a positive rapport and relationship between the provider and family.

Both researchers and practitioners of home-based parenting education and family support programs have highlighted the importance of the parent–provider relationship in achieving program goals (e.g., Hebbeler & Gerlach-Downie, 2002; Jack, DiCenso, & Lohfeld, 2005; Kitzman, Yoo, Cole, Korfmacher, & Hanks, 1997; Roberts, 1997). Gomby and her colleagues assert that “no home visiting program can succeed without a staff that is capable of forging a partnership with families to translate a curriculum into action” (Gomby et al., 1993, p.17). Despite the apparent centrality of the parent–provider relationship in home visiting programs, however, we have limited knowledge about how this relationship develops, functions, and influences program outcomes.

This paper explores ways of understanding the parent–provider relationship from various perspectives and on multiple levels, using the example of the Massachusetts Healthy Families Evaluation (MHFE). First, to place this study in context, we provide a brief overview of the parent–provider relationship literature, the Healthy Families Massachusetts program (HFM), and the evaluation thereof. In the sections that follow, we describe three levels of examination of the parent–provider relationship: 1) “conventional” investigations that rely on program utilization data for information about client engagement, 2) analyses of parent and provider perspectives on the same relationship issues, and 3) observations of the actual client–home visitor interactions during home visits. Our research suggests that such a multi-level exploration of the parent–provider relationship offers a deeper and more complex understanding of this multifaceted and elusive construct.

2. Measuring the parent–provider relationship

The home visiting program literature is filled with exhortations, assumptions, and suggestions surrounding the need for providers to successfully engage their clients. Empirical justifications for these assertions, however, are limited. As Roggman and colleagues observe, “there are few methods developed for examining the content or process of home visits or for evaluating the quality of home visits” (Roggman, Boyce, Cook, & Jump, 2001, p.54). Providers typically work alone with their families, providing few opportunities for others to observe the interaction. Beyond these logistical difficulties, the very premise of home visiting programs, which is to actively cultivate and maintain high levels of intimacy and trust with families, complicates its direct investigation. Thus, the parent–provider relationship has mostly been studied obliquely at best, through the examination of various aspects of the home visit.

2.1. Parent involvement in intervention

Several researchers have addressed the issue of the parent–provider relationship by examining the level or quality of the parent’s engagement in the program. For instance, Powell and colleagues have viewed the relationship in terms of the amount of services delivered by providers to their clients (e.g., Powell, 1994; Powell & Grantham-McGregor, 1989). Heinicke and colleagues (2000) defined program engagement somewhat qualitatively, asking providers to rate (a) the positive connection between the intervener and mother, (b) the mother’s trust in the intervener, and (c) the amount of mother’s work in the intervention process.

An investigation within the evaluation of the Early Head Start program is the first to assess the perceived quality of the relationship from the provider and family perspectives concurrently (Sharp, Ispa, Thornburg, & Lane, 2003). In a study exploring the associations among mother and provider personality, relationship quality, and time spent in home visits, the investigators used a subscale of the Working Alliance Inventory (WAI; Horvath & Greenburg, 1989), a
validated measure of the client–therapist relationship, to assess the mutual attachment of providers and families. They found that relationship quality was predicted by the personalities of providers and mothers, but did not relate to the duration of services. This undermines the assumption that participant involvement in a program is an indicator of the parent–provider relationship.

While the approaches described here can provide valuable information about the intervention process, none of these methods fully captures the parent–provider relationship. Participants’ levels of involvement in services typically reflect much more than the parent–provider relationship, and may in fact not be a reflection of the relationship at all (Sharp et al., 2003). As McCurdy and Daro (2001) explain, “...an individual’s eventual enrollment and full utilization of any voluntary service is a result of a series of individual choices, each of which is shaped by a multitude of events, actors, and contexts” (p. 118). For example, recent findings from the MHFE (see Goldberg, 2006; Jacobs, Easterbrooks, Brady, & Mistry, 2005) suggest that family engagement and participation in home visiting programs might well be related to the extent to which the service modality reflects the cultural community’s preferences, and the amount of “secondary” services (outside the home visit itself) the parent receives. The nature of the relationship as defined by the mother – that is, whether she views the home visitor more as a friend or as a professional helper – might also pertain here, particularly in certain cultural communities, or within certain age groups of participants (as further discussed in a subsequent section).

There are several limitations to a sole reliance on client-completed scales, especially satisfaction scales, in the investigation of the parent–provider relationship. They tend to be one-sided, examining only the parent’s perceptions of the provider, without investigating the provider’s perceptions. Moreover, numerous evaluations in the past decade (e.g., Kochanek & Brady, 1994; Jacobs et al., 2005; McNeill, Nicholas, Szechy, & Lach, 1998; Prevent Child Abuse New Jersey, 2000; Williams, Stern & Associates, 2002) have shown that participant assessments of services and service providers tend to be very high with little variability, making it difficult to distinguish between the experiences of different participants.

The examination of the relationship by Sharp et al. (2003) as part of their investigation of time spent in home visits goes beyond the reliance on client-completed questionnaires and holds promise as a means of getting at the mutuality of the parent–provider relationship. Because understanding the relationship itself was not a main focus of the study, however, the descriptive results on relationship quality were not presented, making it difficult to determine how effective the measure used was in capturing the variability and nuances in the relationship. While the WAI is assumed by Sharp and colleagues to be a reliable measure of the quality of the parent–provider relationship, it would be useful to implement the WAI in conjunction with other measures of the parent–provider relationship to examine its utility in the field of home visitation.

2.2. Perspectives on the relationship

Another body of research and theory on the parent–provider relationship focuses on the roles providers play in the lives of families and the cultural match between home visitors and the families with whom they work.

2.2.1. Role of the home visitor

The role home providers “should” play in the lives of their clients has not been clearly defined, possibly because it varies so greatly among programs. Each home provider’s role is based on the goals of the program, and often the provider’s relationship with each of her clients will be markedly different (Halpern, 1986; Klass, 1996). In fact, many child and family service programs proudly emphasize the individualization of services for their clients. To further complicate the issue, some researchers claim that the parent–provider relationship is dynamic and proceeds through various stages as the client’s needs change (Klass, 1996).

Despite the challenges of identifying the role of the provider, a substantial body of literature exists which highlights the role of the provider as a “friend” and equal to the parent. Osofsky, Culp, and Ware (1988) found that teenage mothers enrolled in a home visiting program enjoyed talking about their personal lives with their providers because they viewed their providers as nonjudgmental friends. Other researchers, however, suggest that the provider’s relationship with the parent should serve as a model for the parent’s relationship with her child (McCullom & Yates, 1994). Examining this issue from a slightly different perspective, several researchers emphasize the limits and boundaries of the provider’s role, specifying, for instance, that the provider is not a therapist or social worker (Hardy & Street, 1989; Ware, Osofsky, Eberhart-Wright, & Leichtman, 1987). Even in this latter case – when
the program itself expects the provider to act as a sympathetic, professional helper who maintains a proper distance from her clients – parents may insist on it being otherwise. The MHFE, for example, found that fully 75% of the participants perceived their home visitors to be friends, with only 16% viewing her as a professional. The remainder of respondents considered the home visitor a parental figure, or thought of her in some other light (Jacobs et al., 2005).

2.2.2. Cultural match between home visitors and clients

Another element in the parent–provider relationships that is often emphasized in the home visiting field is the cultural match between providers and their clients. It is sometimes assumed that a relationship will more readily develop between providers and parents of the same race or ethnicity (Wasik, 1993). The importance of a cultural match in family support programs has not been tested and the nature of the match has not been described, yet many highlight this as a key aspect of home visiting programs (e.g., Hernandez, Isaacs, Nesman, & Burns, 1998; Mason, Benjamin, & Lewis, 1996; Wasik, 1993).

Other providers and researchers maintain that a cultural match between providers and parents is not essential, as long as the providers are respectful of their clients’ cultural identities (Klass, 1996; Proctor & Davis, 1994; Wasik, 1993). Klass notes, “[w]hen parents’ ethnicity is different from that of the home visitor, home visitors’ understanding and respect of the behaviors, attitudes, and values of parents make a personal relationship possible” (1996, p. 72). Without such respect, providers and parents may approach their interactions with prejudgments or negative expectations (Proctor & Davis, 1994). Klass recommends that providers work to “understand and respect each family’s culture; try to recognize differences within, not just between, different family cultures; and see the uniqueness of each family regardless of their culture” (1996, p. 71).

Despite the lively theoretical debate on the importance of cultural match to program success, few research studies exist that examine the degree of the match in family support programs (e.g., Culp & Culp, 2002; Kelsey, Johnson, & Maynard, 2001; Love et al., 2002a,b) or its relative importance to parents and providers, let alone its influence on program outcomes.

2.2.3. Observational tools

Several researchers have developed, or are in the process of developing, observation tools to assess the parent–provider relationship during a home visit (e.g., McBride & Peterson, 1997; Wasik & Sparling, 1995). While these tools are all still in the early stages of implementation, the use of an observation tool by a third party to assess the nature of the relationship holds great promise. As McBride and Peterson (1997) explain,

...observational methods may be the best strategy for describing intervention practices actually being implemented during home visits and for documenting the fidelity of an intended intervention occurring in the home. Nonparticipant observation documenting intervention efforts may well add an important source of data for understanding the complexity of the intervention process, as it is very difficult for an interventionist to simultaneously work with a child and family and objectively detail the variety of tasks he or she undertakes (pp. 213–214).

McBride and Peterson (1996, 1997) developed the Home Visit Observation Form, an observation tool designed to assess Early Intervention home visits. This instrument uses a continuous time sampling system (30-second intervals) to measure three variables: primary interaction, content of interaction, and nature of visitor’s activity or behavior.

The Home Visit Assessment Instrument, developed by Wasik and Sparling (1995), is a more global assessment tool. It includes a pre-visit interview with the provider, a set of scales to be completed by an observer, and a post-visit interview with the provider. The observation scales require the observer to rate how well the provider performs a series of behaviors (e.g., provider uses the parent’s name in greeting, provider warmly greets the child, provider assesses family needs and resources, provider asks about and listens to family’s issues/concerns).

Each of these tools holds promise, but there is little research triangulating these measurements of the parent–provider relationship with other process variables, such as program utilization. In addition, the extent to which these instruments can be applied to other home visiting programs is not yet clear. Finally, the observational tools may fail to
capture the actual dynamic between the parent and provider. For example, the Home Visit Observation Form (McBride & Peterson, 1996, 1997) focuses on the content of the visit and on identifying the participants in the interaction. Such information is essential to understand the specific intervention, but does not directly address the relationship between providers and parents. In another example, the Home Visit Assessment Instrument (Wasik & Sparling, 1995) examines the behaviors of the provider during the visit, but does not examine how the parent might contribute to the interaction and, therefore, the relationship.

In sum, most assessments of the parent–provider relationship tend to be one-sided, examining either the provider’s or the parent’s perceptions and behaviors. Furthermore, even the assumption that positive relationships lead to better program outcomes has rarely been tested, most likely because of the difficulties in adequately assessing the relationship. In fact, in the one existing investigation of the association between the parent–provider relationship and program involvement, no relation was found (Sharp et al., 2003).

The remainder of this paper describes research conducted by the MHFE on the parent–provider relationships in the HFM home visiting program.

3. Description of the HFM program

HFM is a statewide adaptation of the Healthy Families America program — the first “to scale” implementation of a Healthy Families program in the country, to our knowledge. It is meant to be available to all families with a first-time parent under the age of 21. The four main goals of the HFM program at the time of the evaluation were as follows:

- prevent child abuse and neglect by supporting positive, effective parenting skills and a nurturing home environment;
- achieve optimal health, growth, and development in infancy and early childhood;
- promote maximum parental educational attainment and economic self-sufficiency; and
- prevent repeat teen pregnancies.

The specific services offered vary from site to site but include home visits (offered at various frequencies); center-based services, including groups; and referrals to other relevant services.

4. Overview of the MHFE design

The MHFE evaluation plan for the first cohort in the program was rooted in Jacobs’s developmental model of evaluation, The Five-Tiered Approach to Evaluation (FTA) (Jacobs, 2003; Jacobs & Kapuscik, 2000). This model organizes research activities at five levels, “moving from generating descriptive and process-oriented information at the earlier stages [of a program’s development] to determine the effects of programs later [on]” (Jacobs & Kapuscik, 2000, p. 37). The FTA is a developmental and contextual approach to evaluation that is responsive to program variations resulting from the context within which the program is operating, the age and developmental stage of the program, and the program’s evaluation resources and capacity (Jacobs, 1988). The MHFE has focused on the middle three tiers: program monitoring and accountability, quality review, and outcome measurement.

Fig. 1 illustrates the design of the MHFE. The three project components focused on different research questions, all of which are critical to understanding the program operations and effects. The Outcome Study examined the four long-term goals of the program, shorter term goals that we see as intermediate steps toward attainment of the long-term goals and as outcomes in their own right, and factors that might affect the attainment of each of these. The Process Study explored the ways in which the program is operating through three broad areas of investigation: 1) the extent to which sites conform to model and individual program standards, 2) how participants experience the program, and 3) the nature of the home visit. The Ethnography complemented the Process and Outcome studies, examining, through the use of in-depth qualitative methods, the ways in which the program interacts with culture, and community and program beliefs about parenting and help seeking.

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1 HFM has recently added a fifth goal: “to promote optimal parental health and wellness.”
2 In August 1997, the contract for the evaluation of HFM was awarded to a Tufts University team, under the direction of the third and fourth authors. The Tufts team is the independent evaluator charged with documenting the nature and effectiveness of the home visiting program.
4.1. What is the nature of the home visit?

This article addresses one of the central questions of the Process Study: What is the nature of the home visit? In other words, what happens once the door closes behind the home visitor and the family? Specifically, we are interested in exploring the nature of the parent–provider relationship.

In this paper, we present MHFE findings on three levels. In order to link our study with past research, we have examined similar aspects of the parent–provider relationship. First, we focus on the more “conventional” method of study, using program utilization data to draw conclusions about the relationship. Second, we attempt to understand the “match” between home visitors and clients across several dimensions, and the “role” of home visitors in participants’ lives from the participant and provider perspectives. And finally, we present our findings from our pilot study of a home visit observation tool that allows us to code both home visitor and client behaviors during a home visit.

5. Level One: a conventional approach to the parent–provider relationship

Our conventional approach to studying the parent–provider relationship includes examinations of the amount of services provided and parents’ assessments of their relationships with their home visitors. At this level, we use two data sources – a management information system and written questionnaires – to examine the parent–provider relationship.

5.1. Method

The Participant Data System (PDS) is a management information system that contains background information on families enrolled in HFM and details of the intervention provided to these families. The PDS currently contains data on the 17,874 families who have enrolled in the program since its inception. The PDS has seven main data groups into which home visitors enter information about the families with whom they are working: referral, service level, enrollment and family information, pregnancy and birth information, encounter records, status reports that reflect updates of enrollment and family information completed at six-month intervals, and discharge records. The encounter records provide detailed information about the frequency of home visits, who participated in home visits, and the content of home visits.

The evaluation sample of 361 young mothers enrolled in HFM completed two scales that assess their perceptions of aspects of their relationships with their home visitors. At program enrollment, mothers in the evaluation sample were 17.7 years old on average (SD=1.44). At the start of evaluation, the racial makeup of the participants (42.2% White, 11.5% Black, 35.3% Hispanic, and 10.5% Other/Unknown racial groups) closely reflected that of the total population of program participants.
At the first data collection time point, 23.7% of mothers had completed high school or a GED program. Almost all of the mothers (94.6%) were unmarried at the time of evaluation enrollment. Over the course of the evaluation, 21.4% of participants dropped out of the evaluation. Around 65% of participants completed all four data collection meetings (Jacobs et al., 2005).

Participants completed the Home Visitor–Client Relationship Inventory (adapted from Barnard, 1998) three times: at enrollment (N=359), 6 months (N=270), and 18 months (N=160). The scale assesses the extent to which clients perceive their home visitors as respectful and caring. Participants also completed the Family-Centered Behavior Scale (Petr & Allen, 1995) three times: at enrollment (N=359), 6 months (N=208) and 18 months (N=160). The scale assesses the level of family centeredness in home visitors’ work with families. Mothers who had left the program at the 6-, 12-, or 18-month data collection visit did not complete these questionnaires at those visits.

5.2. Results

Analyses of PDS data indicate that, as of June 2002, participants in the HFM program had received, on average, 1.86 home visits per month; families at a weekly service level are expected to receive four visits per month, while families at a biweekly level should receive at least two visits per month. On average, mothers in the sample with an assigned service level received approximately 56% of their expected visits, with a range of 0% to 150% (SD=.29). The average duration of program involvement was around 17 months; families must enter the program before the child’s first birthday and are eligible to participate in the program until their first child turns three years of age (Jacobs et al., 2005).

Mothers’ responses on the Home Visitor–Client Relationship Inventory and the Family-Centered Behavior Scale indicate that they perceived their home visitors as respectful and caring, and that they believed that their home visitors operated in a family-centered way. There was little variability in these measures; almost all of the mothers rated their home visitors as attaining the highest level of functioning possible on these scales. There was almost no change in mothers’ assessments of their home visitors across time, which indicates that, while they were in the program, mothers continued to perceive their home visitor as respectful, caring, and behaving in a family-centered way (Jacobs et al., 2005).

5.3. Discussion

The pattern of results that emerges from the first level of examination is a confusing one. Mothers’ use of the program and the length of their enrollment might be taken to indicate that they are not engaged fully with HFM and, by extension, that they do not have strong relationships with their home visitors. In much of the past research, such findings have been interpreted in this way.

The responses to the questionnaires, however, present a different picture. Mothers consistently gave their home visitors high ratings on the Home Visitor–Client Relationship Inventory and the Family-Centered Behavior Scale, indicating that they find that their home visitors behave in a respectful, caring, and family-centered way. From the questionnaires alone, we could conclude that mothers think their home visitors are doing a good job and that they feel they have good, strong relationships with them.

If our activities had been limited to this first level, we would be left with contradictory information that allows no conclusions to be made about the quality of the client–home visitor relationship. A major shortcoming of the conventional approach (Level One) to the study of the client–home visitor relationship is that it requires too large an inferential leap to comfortably use the resulting data to draw conclusions about the relationship.

6. Level Two: examining both home visitor and client perspectives on the relationship

The MHFE has attempted to address the contradiction evident in Level One analyses by examining the perspectives of both the home visitor and the client on the same issues, thus ensuring greater compatibility of data. Activities conducted at Level Two add more depth to our understanding of the relationship and clarify the role that Level One activities should play in its exploration. This section describes our methods for understanding how both home visitors and teenage parents in the HFM program perceive the home visitor’s role and the importance of a match between home visitors and the families with whom they work.
6.1. Method

Activities at Level Two include interviews with the home visitors and the young mothers participating in the program. These interviews are described in detail below.

6.1.1. Home Visitor Interview

In February 2000, all HFM home visitors \((n=197)\) were invited to participate in an interview covering several topics, including the client–home visitor relationship. In total, 85 home visitors expressed interest in the interviews, and 62 home visitors completed interviews.

Although the PDS does not contain demographic information about the HFM home visitors, the MHFE was able to obtain this information through a variety of other data collection methods.\(^3\) Of the 62 home visitors who completed the Home Visitor Interview (HVI), we have data on 41 (66%). The home visitors were all women between the ages of 22 and 55 years, with an average age of 34 years. The majority of HFM home visitors (90%) were parents, and almost half (49%) of the home visitors had been teenage parents. Although the HFM program is intended to be a paraprofessional home visiting program, the majority of home visitors (90%) had at least some college education. They had, on average, 2.6 years of experience as a home visitor, either with HFM or other home visiting programs. Around two thirds of the home visitors (68%) described themselves as White, 12% as Hispanic, 17% as Black, 2% as American Indian/Alaskan Native, and 2% as biracial. Thirty-nine percent of the home visitors could speak a language other than English (Goldberg, 2005).

The Home Visitor Interview consists of 30 open-ended questions, and takes approximately 45 to 60 min to complete. The interview was tested in focus groups with program supervisors and coordinators, piloted with three Early Intervention home visitors, and revised accordingly. Interviews were conducted either in person or over the phone.

The Home Visitor Interview was designed to cover three broad topics: the client–home visitor relationship, missed visits, and grandparent participation in visits. Two questions specific to the client–home visitor relationship are relevant here:

1. How important do you think it is for home visitors to be similar to their participants in specific ways, such as age, race, ethnicity, religion, parenting status, and life experience?
2. What role do you think you, as opposed to another home visitor, play in the lives of the families you work with?

The home visitor interviews were coded in a manner that would allow quantitative analysis of response frequencies without losing the qualitative descriptions, anecdotes, and examples that home visitors shared. We transcribed six of the interviews in order to develop our coding system. These six transcripts were reviewed, and general categories were developed. Specific codes were developed within each of these categories. After transcribing the first six interviews and developing the coding system, the rest of the home visitor interviews were coded by listening to audiotapes of the interviews. When necessary, we added additional codes to accommodate new material that emerged from these interviews.

6.1.2. Participant Research Interview

Semistructured interviews were administered to HFM participants four times, at six-month intervals, during an 18-month period. The interviews varied in length but covered eight main content areas: parenting, program participation, role of father, role of grandparents, background information, family history, teen functioning, and social support. At Time Two (approximately six months after enrollment), 266 mothers participating in the HFM program and evaluation were asked about the role their home visitors play in their lives, specifically in reference to the following five roles: friend, teacher, parent figure, social worker, and nurse. At Time Four (approximately 18 months after enrollment), 277 mothers were asked about their “match” with their home visitors. Mothers were asked specifically about the importance of a match in race, language, and parenting status.

\(^3\) Home visitor data were derived from the following sources: 1) a demographic survey, which asked the home visitors about their age, race, education, years of experience, etc.; and 2) a staff inventory, which asked program directors to document both demographic and staffing information (dates of hire, reasons for termination, etc.) about their home visitors.
6.2. Results

The paragraphs below, which describe the results from the Home Visitor Interview and the Participant Research Interview, are organized by topic, with the role of the home visitor addressed first, followed by the client–home visitor match.

6.2.1. Role of the home visitor

Home visitors were asked about the role they play in the lives of the young mothers with whom they work. Although we specifically asked about the roles most commonly identified in the literature – friend, teacher, parent figure, social worker, and nurse – many home visitors felt that their role was not included in this list and they suggested others. In addition, many home visitors selected more than one role. In total, 59% of the home visitors identified themselves as a “friend,” although many were quick to qualify this with comments such as “sort of a friend” or “a friend with boundaries.” For example, one home visitor explained, “I am using the word ‘friend’ loosely because I have very clear boundaries with the people I see, but there are some people who look forward to me coming and like to share every detail of their life that’s happened.”

Thirty-three percent of home visitors identified themselves as a resource for information; 23% identified their role as that of family member, such as a parent figure or sister, and 8% identified themselves as a role model. Thirteen percent identified themselves in another way, typically through a description of what they do rather than by naming a specific role, for example, “someone who cares,” “that lady who comes out here,” or “[someone who helps], but with a focus.”

Similarly, mothers participating in the MHFE were asked about the role of their HFM home visitor, again with the following choices: teacher, friend, parent figure or older relative, social worker, and nurse. Mothers overwhelmingly described their home visitors as friends (75.2%). Less than 16% of the mothers identified one of the professional roles (11.3% social worker, 3.0% teacher, and 1.5% nurse). Only 9% identified their home visitor as a parent figure or older relative. Each mother was asked about her satisfaction with her home visitor’s role. Ninety-five percent of mothers described the home visitor’s role as “what they wanted their home visitor to be like.”

6.2.2. Importance of racial/language match

When asked about racial and language match, home visitors’ responses varied, with almost half (48%) reporting that a racial or ethnic match is important. One home visitor (Latina) explained that “it’s easier to understand what Hispanic or Latino families are going through — it helps with understanding food issues, religion, etc.” Describing her own experiences, another home visitor (also Latina) stated, “It’s real important. It was hard when I came here for the first time and didn’t know how to speak the language. My husband and I came with nothing. Right now, what I have, I am giving them. I always tell them, ‘You can do it.’ I tell them about myself and say, ‘If I did it, I know you are going to do it.’” Another home visitor (White) disagreed: “Integration is great. It’s limiting to say that because you are Spanish, you have to have a Spanish advocate.”

Twenty-one percent of home visitors felt that a racial/ethnic match is important in terms of language — in other words, that the home visitor should speak the same language as the participant. One home visitor explained the importance of language in gauging the child’s development: “With families that don’t speak your language, you don’t know if the baby is on track.”

Mothers enrolled in the evaluation were asked about a match in terms of race and language. Sixty-five percent of the teenagers reported having a home visitor of the same race. In contrast to popular beliefs about the importance of a racial match, an overwhelming 80% of the mothers said that having a home visitor of the same race is not at all important.

English is not the first language for 85 of the participants (31%). Of these mothers, 51% reported that their home visitor always speaks their native language with them, and an additional 13% said that their home visitor sometimes does. However, only 34% of these mothers reported that it is important to have their home visitor speak their native language with them.

6.2.3. Importance of match in parenting status

When we asked home visitors about a match in parenting status between visitors and clients, almost half of the home visitors (46%) reported that being a parent is central to the establishment of a relationship. One home visitor’s response exemplified the general attitudes of the home visitors: “You can’t talk with them about being a parent by reading a
book. You need to have experienced it.” Similarly, another home visitor explained, “They’re not going to listen to someone who doesn’t have children.” An additional 25% of home visitors explained that being a parent is helpful, but not necessary: “It is helpful to be a parent, but the most important thing is compassion.” One home visitor stated that a match in parenting status is not important, but then questioned her own view: “I’m not a parent and that hasn’t made a big difference, although, actually, that might have played into the case of the person that I transferred to another home visitor since the other home visitor was already a parent.” A few home visitors mentioned how helpful it was that they had been teen parents themselves; as one home visitor said, it is “important for the teens to know that you know where they are coming from.”

When asked about the same issue, 82% of mothers reported having a home visitor who is a parent. Approximately half of the mothers (51%) believed that having a home visitor who is a parent is important.

6.3. Discussion

Although there are instances of overlap, home visitors and teenage mothers do not always agree on the two issues of home visitor role and client–home visitor match as related to the client–home visitor relationship. Both home visitors and mothers describe the home visitor’s role as that of a “friend,” although home visitors are careful to qualify such statements in order to emphasize their professional status. From this research, it is not clear what “friend” means to home visitors and clients. Are they using the word “friend” the way they would to describe a close relationship with a peer? Or are they relying on the word “friend” for lack of a more accurate term to describe some other unique quality of the client–home visitor relationship? Further research is needed to fully understand how home visitors and clients might characterize the home visitor’s role.

Home visitors and clients disagreed about the importance of racial match; home visitors were much more likely than mothers to identify a racial match as important. This is particularly interesting in light of the fact that so often in the family support literature, researchers and practitioners assume that a racial match is critical. It is difficult to separate racial match from language match. Approximately one fifth of home visitors described a racial match as important in terms of speaking the same language as their participants. Similarly, one third of the mothers for whom English is a second language described a language match as important.

There was more agreement between home visitors and clients on the subject of parenting status match; approximately half of the home visitors and clients perceived that a parenting status match is important — that is, that it is critical for home visitors who are working with new parents to be parents themselves. This finding has implications for home visitor hiring, training, and supervision.

7. Level Three: observing the client–home visitor relationship

Levels One and Two descriptions of the client–home visitor relationship provide important information about the nature of the home visit, but are limited in their ability to characterize the interaction between home visitors and clients. We believe that observations of home visits can provide greater insight into the rapport that develops between a home visitor and a parent; at the same time, we recognize the challenges to interpreting observational data, particularly those that focus on interpersonal relationships, across cultural groups. With that caution in mind, we next describe a pilot study of a small sample of home visits and an observation tool developed to assess the quality of the relationship between home visitors and clients.

7.1. Method

Home visitors working for the HFM program were asked to videotape their home visits and provide these tapes to the MHFE team. The evaluation team explained to program coordinators and home visitors that this project was designed to help understand how home visiting works, and how home visitors develop helping relationships with families.

7.1.1. Participants

The evaluation team recruited home visitors from the HFM program who met the following two criteria: (a) the home visitor must have completed a demographics survey as part of another MHFE Process Study activity ($n=197$); and (b) the home visitor must have at least one client who is participating in the MHFE Outcome Study. These criteria
were used in order to have data from several sources to triangulate with results from the home visit observations. Home visitors who met these criteria were asked to tape all their visits during a one-month period with one or two clients who were enrolled at the time in the HFM program and the evaluation.

For this phase of the project, the research team sent out recruitment letters to 67 home visitors, asking them to videotape their home visits with 117 teenage mothers enrolled in both the HFM program and the MHFE. The home visit videotaping project was voluntary for both home visitors and mothers, and some home visitors and mothers refused to participate. In addition, at the time of this substudy, a significant number of mothers had dropped out of the program and, due to high staff turnover, many home visitors were no longer working for the program. As a result, this study relied on a small sample: 26 home visitor–mother pairs, for a total of 54 videotaped home visits (some home visitors recorded multiple visits with the same participants).

7.1.2. Videotapes of home visits

Each HFM program was given a video camera by the Massachusetts Children’s Trust Fund to be used both for the client–home visitor relationship videotape project and for teaching purposes within the program. Participating home visitors were asked to place the video camera on a tripod at the beginning of the home visit and to let the camera run for the entire visit. However, many home visitors chose to bring a colleague from their program site to record the visit. Visits varied in length, ranging from 15 min to 90 min, although the majority of visits were approximately 35 min long. Ten home visits were conducted in Spanish.

7.1.3. Observation tool

Videotapes of home visits were coded using a two-part Home Visit Observation Scale developed for this project. The first part of the scale is a Home Visitor Observation Tool adapted from the Home Visit Assessment Scale developed by Wasik and Sparling (1995), which assesses the home visitor’s behaviors during the home visit using a four-point Likert scale. This tool was simplified to a three-point Likert scale and modified to fit the goals and expectations of the HFM home visiting program. The second part of the Home Visit Observation Scale is a Participant Observation Tool, which assesses the behaviors of the mother during the home visit. Each home visit received a home visitor score from 0 to 1.0, and a participant score from 0 to 1.0, and a combined score calculated as an average of the home visitor and participant scores. Using the two components of the scale together allows for a more complete understanding of the nature of a home visit, how home visitors develop relationships with their families, and how home visitors and clients interact with each other.

The Home Visit Observation Scale is designed to evaluate the home visitor’s behaviors during the home visit, and the mother’s responses to and involvement in the home visitor’s discussion and/or activities. Many of the questions on the Home Visitor Observation Tool complement questions on the Participant Observation Tool. For example, the observer is asked to rate the extent to which the home visitor asks the mother about herself, her activities, her family, school, and other aspects of her life. The observer is also asked to rate the extent to which the participant shares information about herself with her home visitor. It is possible for a home visitor to ask the mother many questions about herself, but to receive minimal responses. It is also possible for the home visitor not to ask any questions about the mother, but for the mother to volunteer information about herself. And, in some cases, neither the home visitor nor the mother may discuss the mother’s life. Including both items on the scale allows the researchers to differentiate among these various possible combinations.

Other items on the Home Visit Observation Scale are targeted primarily to the home visitor; this emphasis reflects the fact that the home visitor has primary responsibility for setting up and maintaining the home visit situation. For example, the Home Visitor Observation Tool requires the observer to rate the extent to which the home visitor explains the purpose of the visit (the topics to be discussed, the activities to be conducted, etc.). Similarly, the observer must rate the extent to which the home visitor praises or compliments the mother for a particular behavior or achievement.

Each home visit was coded using the Home Visit Observation Scale by trained graduate students. One third of the videotapes were rated by a second coder for interrater reliability ($\rho=0.95$). Disagreements were reviewed and discussed until agreement was reached.

7.2. Results

Dyadic analyses (as described by Kenny, 2004) were conducted on the entire sample of 54 videotaped home visits. In addition, further analyses were conducted on particular subsets of data.
7.2.1. Entire sample
A wide range of scores were obtained on the Home Visit Observation Scale (0.48 to 0.95 for the Home Visitor Observation Tool; 0.23 to 0.97 for the Participant Observation Tool). Scores for home visitors and mothers in each dyad were highly correlated ($r = 0.68$, $p < 0.001$; see Fig. 2). However, aggregate scores for home visitors and mothers were significantly different from each other (paired samples $t$-test, $t(53) = 6.28$, $p < 0.001$). Overall, home visitor scores (mean = 0.80) were approximately 0.12 higher than participant scores (mean = 0.68).

7.2.2. Home visitors with the same participants for multiple visits
Fifteen participants were videotaped for multiple home visits with their same home visitor. Although several of these participants were videotaped for three or four visits, these analyses focus only on the first two visits for each participant–home visitor pair because of the small sample size. Intraclass correlation coefficients were obtained for home visitor scores across visits since these scores were not independent of each other. Home visitor scores across the two visits were highly correlated ($\rho = 0.82$), and participant scores across the two visits were moderately correlated ($\rho = 0.49$). Combined scores for each dyad were only slightly correlated ($\rho = 0.30$) across the two visits.

7.2.3. Home visitors with multiple participants
Five home visitors videotaped their visits with two participants. Home visitor scores with each of their participants were inversely correlated ($\rho = -0.89$), indicating that home visitor scores with one participant were different from their scores with another participant. As a group, however, home visitors and participants were not significantly different from each other in their scores ($t(4) = -0.064$, $p = 0.952$). Combined scores for dyads (average of home visitor and participant score for each dyad) were not at all correlated ($\rho = -0.09$), indicating that the relationship was very different across families, even with the same home visitor. Although these analyses were conducted on an extremely small sample, the results demonstrate the importance of focusing on the dyad rather than solely looking at the home visitor.

7.2.4. Participant with multiple home visitors
One participating mother went through a home visitor change during the time of this project, and she was videotaped during home visits with two different home visitors. It is interesting to note that the home visitor and participant scores were quite different across the two home visitors: 0.65 and 0.70, respectively, for the visit with the first home visitor, and 0.93 and 0.88, respectively, for the visit with the second home visitor. While anecdotal, this case seems to
correspond with the data presented above for home visitors with multiple participants, again demonstrating the need for assessing the entire dyad rather than individual members.

7.3. Discussion

The Home Visit Observation Scale is still in its pilot phase, and has been tested on only a small sample. However, results support the utility of this instrument in differentiating between the relationships of various participant–home visitor dyads.

One particularly interesting finding was that, although home visitor and participant scores were correlated, they were significantly different from each other, with home visitor scores that were slightly higher than participant scores. This difference may reflect the home visitor’s responsibility in facilitating the interaction: the Home Visit Observation Scale is designed to assess the home visitor’s behaviors and the participant’s responses to these behaviors. The scale is based on the assumption that the home visitor carries a greater burden in that it is her/his job to establish the visit parameters, and assist the mother in participating in the interaction. This is not meant to reduce the parent’s role in the interaction; rather, it reflects the professional role of the home visitor within the dyad.

Other findings highlight the importance of the participant’s contribution to the interaction. The scores of home visitors videotaped with multiple participants were inconsistent, indicating the need to examine the entire dyad, with a specific focus on the participant’s role. However, it should be noted that this was a particularly small sample of five home visitors, and that each of these home visitors was only observed with two participants. Further investigation is needed to determine if this pattern is present in a larger sample of home visitors with multiple participants.

Participant–home visitor pairs who were videotaped for more than one visit demonstrated some consistency across visits, although home visitor scores showed more consistency than participant scores, suggesting, perhaps, that home visitors are able to maintain a more consistently professional demeanor across clients. Again, however, these findings were for a very small sample of participants, and without further research it is impossible to know whether these patterns would hold in a larger sample of participant–home visitor pairs who are taped for multiple visits.

There are several limitations to this study. First, this study used a small, non-random sample of home visits. Furthermore, these home visits reflected a small sample of participant–home visitor dyads \( (n=26) \) over a one-month period. It is not possible, therefore, to generalize to other participant–home visitor dyads within the HFM program, let alone to other programs.

Second, the observed visits took place at various points within the client–home visitor relationship. Members of each dyad had known each other for various lengths of time, and these times were not tracked in any systematic way. It is not clear, therefore, what effect the length of the relationship had on the dyadic scores on the Home Visit Observation Scale. It is possible that relationships between home visitors and clients develop over time, and that scores on the Home Visit Observation Scale would change over the length of the relationship. Alternately, it is possible that the relationship is established early on, and that once established there is little variability. Further examination is necessary to test these hypotheses.

Third, the actual taping of the home visits varied a great deal. Some home visitors placed the video camera on a tripod stand and allowed the camera to run for the entire visit, but in other cases, home visitors brought along a colleague from their agency to run the video camera during the home visit. While this improved the quality of the videotaping, it is unclear how the presence of another person affected the interaction. In addition, it was clear that the use of video cameras was new for many home visitors (and other program staff), and that training with the cameras before beginning this project could have been beneficial.

8. Summary and conclusions

By examining the parent–provider relationship on several levels, we are able to begin exploring its many dimensions, and by so doing, to demonstrate its complexity. Each level of investigation has its merits and its disadvantages; however, it is the third level, the in-depth observational methods, that provides the most sophisticated understanding of the relationship.

Level One analyses, based on quantitative data such as visit frequency, program duration, and standardized scales, allow only for incomplete and inconsistent measurements of the client–home visitor relationship, and the findings actually can be quite inconclusive, and, in some cases, misleading. They provide potentially unreliable information
about whether or not relationships are positive or negative, and they provide little information about what constitutes positive or negative relationships, or which aspects of the relationships are most important.

Level Two activities, which rely on qualitative interviews with program participants, allow both the home visitors and the mothers to provide their perspectives on their client–home visitor relationships. In our study, the home visitors and the mothers did not always agree on the home visitor role and the client–home visitor match, highlighting the importance of examining both perspectives. These types of analyses add depth to our understanding of the parent–provider relationship, and help us to question some of what has been written in the literature. For example, whereas the literature maintains the importance of the parent–provider racial match (e.g., Lowenthal, 1996; Torralba-Romero, 1998), our research suggests that, while home visitors tend to concur, HFM mothers do not consider the racial match to be important. Further research may illuminate why mothers view this issue so differently from home providers, programs, and researchers. It may be that providers mention the match as important because, from a professional standpoint, their goal is to find personal connection with the mother in order to further their professional agenda. Providers, by the very nature of their jobs, may be more deliberately attuned to possible areas of commonality and connection with their clients. The parents, however, the majority of whom are satisfied with their providers, may not be as motivated to contemplate the reason for this positive relationship, or to attribute it to any particular commonality or theme. While Level Two analyses have allowed us to examine some of the individual issues considered critical to the parent–provider relationship, they still do not provide a complete picture of the relationship.

Level Three analyses, which are based on observations of home visits, allow us to examine the parent–provider relationship much more deeply. The Home Visitor Observation Scale allows us to understand the specific components that contribute to each particular dyadic relationship. For example, the scale could show that a mother who does not appear to be at ease during the visit may have a home visitor who neglected to establish any kind of rapport; or a mother who seems reluctant to share personal information may have a home visitor who behaves in a particularly judgmental manner. By examining specific behaviors within the context of the interaction, we develop a much better understanding of exactly how each relationship seems to function. The Home Visit Observation Scale also allows for a more global assessment of the overall relationship within each client–home visitor dyad, based on the behavior of each member.

In summary, while quantitative assessments may provide us with important information about the nature of home visits, such as who is present at the visit, what is discussed, and how each member of the dyad may feel about the relationship, observational methods allow a much more dynamic view of the relationship between parent and provider.

We believe that this approach holds promise for both theory and practical application: Not only can it help us to describe and measure the different components of the parent–provider relationship, but it could also be an extremely helpful teaching tool for instructors and supervisors in the family support field.

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References


