

# Occasional Paper

## Harder Than You Think

**Determining what works, for whom,  
and why in early childhood inter-ventions**



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**ABSTRACT:** After more than a decade examining the process of intervention among young mothers and service providers—including paraprofessionals, doulas, and therapists—Jon Korfmacher suggests that → [continued](#)

← policymakers who ask “What works?” may be missing a more fruitful, if more complicated, line of inquiry. In this paper, Korfmacher examines the difficulty and potential benefit of installing a window on the black box of intervention.

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### **About the author**

Jon Korfmacher, Ph.D., is an assistant professor at Erikson Institute. He received his B.A. in psychology from Stanford University in 1988 and his Ph.D. from a joint program between the Department of Clinical Psychology and the Institute of Child Development at the University of Minnesota in 1994. Although trained as a clinician, he has focused most of his professional life on research. From his early years as a doctoral student, Jon has been interested in studying program processes in early childhood interventions, exploring how different families with young children respond to these programs.

After completing a clinical internship in New Mexico, he worked for five years at the University of Colorado Health Sciences Center in Denver. There he split his time between working on the randomized trials of nurse home visiting programs developed by David Olds, participating in the national evaluation of Early Head Start, receiving additional clinical training in the Harris Infant Mental Health Training

Program, and working as a therapist at a child abuse treatment center.

Since 1998, he has been a member of the faculty of Erikson Institute, where he teaches and conducts research. In addition to his position at Erikson, Jon serves on the board of the Illinois Association for Infant Mental Health, where he is chair of the research committee. He is a member of the steering committee of the Early Career Preventionists Network (an Internet-based group devoted to prevention programs and prevention science) and is on the Chicago Metropolitan Regional Board of Children’s Home and Aid Society. In 2001 he was named a Solnit Fellow in Zero To Three’s Leadership Development Initiative.

**Interviewer:** Why did you decide to join the [home visiting] program?

**Teen Mother:** The y just enrolled me in it...So that's how I got in it...One of my friends was in the program,too . And she talked me into getting into it.

**Interviewer:** What did you think you could get help with? Or what did you want help with?

**Teen Mother:** I didn't think I could get help with nothing. I didn't really want help . I really don't ask nobody for help.

**Interviewer:** You didn't ask anybody for help? So why did you join the program then?

**Teen Mother:** I don't know.This what I was asking [home visitor] like, "What do this program give us?" Cause I don't see what they give us....Like I know a program that helps, you know, they give out....Pampers and stuff like that.We don't get nothing. I don't know.

WHEN A PARENT WITH A YOUNG CHILD enters a support program, what is he or she really hoping to get out of it? What motivates a family to seek out services, to engage with a program, to form a relationship with staff? Once in a program, what is the difference between a family that drops out and one that stays in? And if a family does "take" to a program, is the family really getting anything out of it? If a mother or father feels supported by program staff, is that going to make a difference in the life of her or his child?

You would think that after 30 years of studying early childhood intervention programs there would be some pretty impressive things to say about these issues, that social scientists in lab coats could throw up some charts and graphs and say with great confidence that X are the parents we can most help and that Y is the best program model, with Z maybe needing to be factored into the equation. In this dream, there is also a line of prominent academics testifying before legislators with such certainty and clarity (a clarity that can only exist when backed up by mounds of data) that our elected officials from both sides of the aisle come together in a sense of urgent bipartisanship and vow to do whatever it takes to get these services to those families in need. There does not have to be singing and dancing in this dream, although that would obviously carry the mood.

Sadly, no such scenario exists in the real world (although a line of prominent social scientists singing and dancing may be something to miss). Where we

are now is fractured, messy, opinionated, and complicated. There is no magic bullet of intervention that can fix troubled families and little agreement among program evaluators and other applied development researchers as to the best way to proceed. One widely read review, for example, tells us that home visiting interventions have only small, scattered impacts on young children and their families, while another review that same year extols their virtues (Gomby, Culross, and Behrman 1999; Zero to Three 1999). The (very) general conclusion that emerges, based on a number of reviews, is that early childhood interventions can be helpful to families, at least modestly; long-term longitudinal investigations suggest that there can be a cumulative benefit to society over time (Karoly et al. 1998; National Research Council and Institute of Medicine 2000). Does this make these programs worth our investment of energy, attention, and resources? As is often said at Erikson, that depends.

One reason for the lack of agreement is the difficulty in establishing parameters for the field. There is a “pervasive idiosyncrasy and diversity” (Halpern 1984, 36) to early childhood intervention programs, which are, in essence, any intervention and support programs designed to promote the health and development of children from birth to five years of age. Programs for young children and their families encompass a large number of professions, aspects of development, and methods. They include programs that provide direct service to children as well as those that attempt to affect the young child’s development indirectly through support to the parent.<sup>1</sup> The targeted domains of development may be cognitive, social, emotional, physical, or family, in any combination. They may occur in the home, office, or center, in any combination. Interveners may be paraprofessionals, nurses, social workers, child development specialists, early childhood educators, counselors, childcare workers, psychologists, or psychiatrists. The number of sessions can range from one to hundreds, with programs lasting from hours to years. As can probably be guessed by now, these services are not part of any one public system, nor are they guided by any coherent public policy or legal strategy. Drawing general conclusions from such an eclectic array of programs is a little foolhardy to begin with, but there is more to it than that. It is not just the diversity that exists *across* programs but the diversity that exists *within* programs.

<sup>1</sup>Many programs (especially home visiting programs) focus primarily on the caregiver as a target for intervention, even though the child can easily be seen as an equal participant in early childhood interventions. This is because the caregiver is viewed as the gatekeeper to the young child, and the one most responsible for the child’s safety and well-being. The studies I describe in this paper have this bias and primarily focus on the caregiver. See Korfmacher and Spicer 2002 for an example of a study that examines the child’s experience in an Early Head Start program.

## Looking Inside Programs

I make the argument that a big reason we as researchers know so little about what happens inside programs is because we rarely bother to look inside

the program to *see* what is happening. Much of the focus of early childhood intervention research has been on outcomes: Does the program work? This has been the question that most interests stakeholders such as funders, policymakers, and legislators. The best way to answer it is by comparing families who take part in an intervention with other similar families who did not participate in the program.

To examine these two groups well, one must rely on a necessary evil of evaluation—the randomized trial. In this research design, participants are randomly split into two groups—one that is allowed to participate in the program and the other that is not. Randomized trials are our gateway to legitimacy in the sciences. They are the “gold standard” of program evaluation (National Institutes of Mental Health 1993; Institute of Medicine 1994), the one way to tell with a reasonable degree of certainty that a program actually has (or fails to have) positive impacts on families above and beyond other resources or baggage that families bring with them. Randomized trials and other elements of “positivist” approaches to program evaluation require a certain amount of objectivity, standardization, and control (Hauser-Cram et al. 2000). But by adhering to such methodological rigor, crucial information often gets lost in the process.

Outcome studies can tell us *if* a program has an impact but they cannot tell us *how* it does this. The long-standing analogy is of the black box of treatment: Families enter it, something great happens, and the families (hopefully) come out shinier, stronger, and more resilient. But what happens in that black box? There is an implicit assumption in the randomized trial design that what happens in the box is the same for all families; the “intervention” is a monolithic entity that is unvarying across all participants. Any differential response—the family that never shows up, the home visitor who rubs the caregiver the wrong way, the TV that is always blasting *Who’s The Boss* reruns during home visits—becomes simply error variance.<sup>2</sup> But as anybody with any connection to intervention programs knows, families do differ greatly in how they respond. We cannot assume that the experience inside the box is the same for all who enter. And it is in this difference that the real heart of the intervention lays.

Recently, there has been an increased interest in putting a window in the black box and peering inside. The question to ask is not Does the intervention work? but How does it best work? For whom? Under what circumstances? This involves more complicated analyses, examining participants, program features, the community or environment where families live and programs operate, and the area where all these factors intersect. This line of inquiry is

<sup>2</sup>I mean no disrespect to the creators of the seminal ’80s sitcom *Who’s The Boss*. I used this show for illustration since its title evokes the struggle that home visitors have when the TV is on: Just who is in control of the situation? Can the visitor ask for the TV to be turned down? Actually, the show that gets anecdotally mentioned most by home visitors as being on and very loud is *Jerry Springer*, about which the less said the better.

sometimes noted as the study of process, since it is often focused on the processes by which interventions work (or fail to work) and the meanings that participants place on the program. It has also been referred to as part of a post-positivist approach to evaluation (Hauser-Cram et al. 2000). I have been phrasing the issue simply as *understanding the experience* of the intervention (Emde, Korfmacher, and Kubicek 2000).

There are many different ways that one can conceptualize program experience, but I have found it useful to think of it in terms of four general dimensions: (1) quantity of contact (How often or for how long does the family meet with the program staff?); (2) quality of contact (How is that time spent?); (3) topic of contact (What specifically is focused on during this time?), and; (4) service provider (What is the background and training of the person providing the services, and what support do they have?). All of these are to some extent interrelated. That is, quality of contact may be related to quantity of contact (if you have good feelings about a childcare program, you will likely have your child spend more time there), or topics of contact (if you have a strong working alliance with a therapist, you will probably go “deeper” on issues than if you do not), or service provider (you likely spend time differently with a pediatrician than you do a childcare worker).

Space does not permit a review of all of these dimensions, so for the remainder of this occasional paper, I will focus on just one element of the dimension I have identified as quality of contact: the helping relationship that forms between provider and client. Even though the helping relationship has been frequently invoked as an important element of program success, it has not been a major topic of early childhood intervention research. I will use my own research to illustrate how one may examine it. I do this not out of hubris (ok, maybe a little), but to illustrate how complicated it can be to capture program experiences with any empirical rigor yet remain truthful to their complex nature.

### “It’s the r relationship”

By now, this is a mantra in early childhood intervention programs. The relationship that develops between provider and family/parent/child/client is seen as absolutely crucial to program success. While undoubtedly true for interventions across the life span, this relationship is even more important in the eyes of early childhood researchers and practitioners, owing to their strong orientation to the centrality of relationships—including those between parents and children—in

the lives of young children. Administrators, clinicians, and program evaluators have all emphasized this notion (Olds and Kitzman 1993; Heinicke and Ponce 1998; Klass 1996; Berlin 1998).

As a graduate student, I became very interested in the helping relationship. This came partly from reading the wonderfully evocative case studies of Selma Fraiberg as she articulated principles of infant-parent psychotherapy with very distressed families, partly from my own beginning training as a therapist, and partly from my academic background in attachment theory, which is all about the formation of emotional closeness between parent and infant (Fraiberg 1987; Cassidy and Shaver 1999). In attachment theory, the first central relationship that develops between caregivers and children is necessary for the infant to survive and thrive and serves as a template for later relationships. Is there a corollary in working with families? Is the relationship that develops between a helper and the family-client also needed for the family to grow and change?

I was tremendously excited about the notion of the “corrective emotional experience,” where the time spent in therapy with a caring and supportive other *is* the mechanism whereby people see themselves as deserving of care and support. And when parents see themselves as deserving of care and support, then it is just a short step away from providing this care and support to their own child (Erickson, Korfmacher, and Egeland 1992). This “empathy hypothesis” suggests that the perception of felt security and support from an important person like a therapist or home visitor leads to the parent showing greater empathy and concern for their own child. There was, in fact, some research that indirectly supported such a link in terms of breaking the inter-generational cycle of maltreatment.<sup>3</sup>

But how to capture this alliance, this “change agent,” in all of its glory? For the past decade I have been exploring different ways to look at the helping relationship across a variety of programs, providers, families, and methodologies. I began in graduate school, working on a home visiting program for young, first-time, low-income mothers.<sup>4</sup>

## The Role of Early Experience in Helping Relationships

Project STEEP (Steps Towards Effective Enjoyable Parenting) had a strong infant mental health component, influenced by the work of Selma Fraiberg and longitudinal studies of parent-child attachment. It was a year-long program that emphasized home visits and parent support groups, targeting first-time, low-educated, young, low-income mothers.<sup>5</sup> Home visitors and group leaders

<sup>3</sup>The most influential study showed that the difference between mothers with histories of child abuse who did or did not maltreat their own children was the presence of an important supportive relationship, including a therapeutic relationship (Egeland, Jacobvitz, and Sroufe. 1988).

<sup>4</sup>Although it is certainly true that early childhood interventions are open to either father or mother (or other parental figure), all of the interventions that I discuss in this paper almost exclusively focus on mothers.

<sup>5</sup>Current versions of the program last longer, until the child's second or third birthday. For more on STEEP, see Erickson et al. 1992.

were paraprofessionals, although they tended to be fairly experienced paraprofessionals with college degrees in the social sciences and human services.

STEEP had as a goal to correct internal working models of attachment relationships. It was hoped that the relationships that developed between the mothers and home visitors and among the mothers in each group would be a positive force for people without much emotional support, and that it would change how they organized their sense of relatedness with their own child and with others. But, as is common for early childhood intervention programs, STEEP also had a “kitchen sink” approach: families were to be supported in almost all the areas that they wanted or needed help. So assisting mothers with finding housing, with conflicts with family members, with their own dreams for the future—all were considered important avenues of intervention to support the young women in being caring and sensitive parents.

On this project I had the privilege of reading the home visitor case notes in order to develop a systematic way to examine program processes, and it was in the reading of these case notes that the complicated nature of these relationships quickly became apparent to me (see “Relationships Are Complicated,” opposite). I developed rating scales to capture how the young mothers engaged with their home visitor over the course of the one-year program and what “level” of therapeutic support they would tolerate in the time spent. For example, could they talk about personal issues with their home visitor, or did the time together seem more like chatting? Could the home visitor and mother work together on long-term problem solving, or did they just deal with immediate crises?

The most interesting finding that emerged was that the mother’s mental representation of her childhood attachment relationship was related to her use of the program in theoretically significant ways (Korfmacher et al. 1997). The mother’s own history of care from her childhood—or at least, how she currently *thought* about her history of care—was related to how emotionally engaged she was in the intervention. Mothers with a *secure* sense of their history (who could talk about both positive and negative memories in a coherent and realistic way) showed the strongest ability to connect with their home visitor and used the program for emotional support. Mothers cut-off from emotionally significant early experiences (considered *dismissive* of their early childhood relationships) showed more superficial relationships with their home visitor. Those disorganized and emotionally overwhelmed with their (mostly negative) memo-

ries (considered *unresolved* with respect to their early relationships) used home visitors primarily for crisis purposes. In this sense, mothers who most needed a supportive helping relationship were the least likely to use the relationship in ways that could be helpful.

This study illustrates in particular the complexities of examining this issue. Dismissive mothers had an equally high level of contact with their home visitors as mothers with more secure representations. Notes by the home visitors, however, suggested that the dismissive mothers' emotional involvement in the sessions was fairly shallow. In other words, although these mothers were often available for visits, they seemed to keep their home visitors at an emotional distance, paralleling their avoidance of emotions when reflecting on their relationship history. So even though, as noted above, we often assume a relationship between quantity and quality of contact, this is not always the case. In fact, very similar results have been recently reported with a group of mothers participating in an Early Head Start program (Robinson et al. 2001). Mothers more dismissive of close relationships showed more superficial engagement in their home visits, present but not invested.

Ultimately, the lesson that emerged from this finding—which becomes a recurring point in the research that follows—is that it takes more than just meeting with the family to provide help. Clients are likely to place the helping relationship into their model of what relationships should be like. So, for an intervention to be a corrective or transformative experience for a highly stressed family, it takes considerable thought and effort. Having a friendly person to come and visit and give parenting advice is not enough for many families who

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## Relationships Are Complicated

Here is a specific example (based on an actual case note, although details have been changed): A paraprofessional home visitor working with a young, first-time mother with a toddler son realizes that this mother is in a very emotionally and physically abusive relationship with the child's father. She works carefully and supportively with the mother to boost

the mother's confidence and self-esteem so that the mother has the courage to leave the relationship, to develop an escape plan so that the mother and child can quickly get out if they feel threatened, and to assist the mother in finding alternate housing for her and her child when she decides to leave. This is all accomplished with great difficulty,

as there are many complicated factors that tie the mother economically and emotionally to the abusive partner.

Both are worried as to how the partner will react. And yet the home visitor feels confident in the progress this mother is making, and the mother begins making tentative steps to leaving this dangerous situation.

Then one day the home visitor arrives at the family's house to see the mother's possessions thrown out on the front lawn. The partner has kicked the *mother* out of the house. He wants to end the relationship. To the home visitor, this was the best-case scenario: the mother is actually encouraged to leave by the partner. Much to her dismay, however, the home visitor witnesses the mother pleading and crying with the boyfriend to take her back.

What is the home visitor to do in this situation? To her supervisor she has to be honest and admit her feelings of disappointment at the mother for not taking this opportunity to leave, for wanting to continue a relationship that is so dangerous. But most of all, the home visitor feels betrayed by the mother, that all of the support and ego-boosting she provided the mother has come for naught. How does the helping relationship continue under these circumstances? How can the home visitor feel successful about her work with this mother? What if, in spite of all of this, there are other signs of

progress: the mother-child relationship seems strong, the child is enrolled in a high-quality day care?

To add a further complication, what if the home visitor herself is a past victim of domestic violence? Seeing the mother in this situation brings up many old feelings that the home visitor has a difficult time dealing with, memories of helplessness, vulnerability and worthlessness.

This in part may be what is driving her to assert so strongly to the mother the need to move out—so that the mother does not have to experience any more the pain she went through, but also so that the home visitor does not have to relive this pain as well.

We might recommend, as long as the child can remain safe, that the home visitor be patient, recognizing that the process of ending an abusive relationship takes time (as it may have in her case). But how hard is this going to be for the home visitor? How can the supervisor help her deal with her own feelings? One may also argue that is not the home visitor's role to be patient—that she needs to be the advocate, the voice, the one who says to the mother that staying where she can get hurt is not acceptable. In short, how does the home visitor clarify her role, handle her own history, have genuine feelings about her client, keep the child safe, and remain supportive and helpful?

are wrapped in thick armor of pain and denial. A well-referenced writing about the Clinical Infant Development Program notes that the important feature of an intervention is for there to be “a person to talk to who really cared” (Pharis and Levin 1991). But we need to know more about exactly what it means to care, and how families may recognize and value this care.

## Relationship Disruption

I had the opportunity to explore these issues further with an even larger group of program participants when, after graduate school, I worked on a series of home visiting trials conducted by David Olds. This program model uses public and community health nurses to visit first-time, low-income mothers from pregnancy until the child’s second birthday. The program is designed to improve the mother and child’s physical health and development, improve the mother’s caregiving abilities, and support her in achieving her own life goals (such as education or employment). Like the model described earlier, it has a “kitchen sink” approach, although using public health nurses places its orientation away from mental health issues and towards a focus on child health and safety (Olds et al. 1997).

There were two very different ways that I looked at the helping relationship in this program, using data from a trial conducted in Memphis, Tennessee. In the first investigation, I took advantage of the fact that not all mothers began and ended the program with the same home visitor. If a strong, on-going helping relationship is an important aspect of delivering services, then what happens when the relationship is *disrupted*? There was a fair amount of staff turnover in Memphis, so that one-third of mothers had more than one visitor over the course of the intervention trial. I could examine how these relationship disruptions effect program outcomes by comparing those families who had to start again with another visitor to families who had only one visitor through the entire intervention (Korfmacher, McCullough, and Olds 1997).

I hypothesized that this disruption would have negative effects on program outcomes, so that families who were in disrupted relationships would have worse outcomes than those not in disrupted relationships, although those with disrupted relationships would still do better than those mothers who received no intervention at all (that is, moms in the control group). In general, this is what I found. By the end of the program, mothers with disrupted relationships reported lower feelings of mastery and harsher, less empathic attitudes towards

the needs of young children (based on their responses to a self-report measure) than the mothers with continuous relationships. They did, however, have more positive outcomes than mothers who did not receive any home visiting.

What is really interesting is that *most* affected by this relationship disruption were mothers who reported a childhood history of rejection from their parents. Mothers with this history of rejection seemed to have a harder time adjusting to the transition to a new home visitor. They may have been more inclined to see this disruption as a form of rejection from the home visitor. This echoes the findings from STEEP noted earlier: Parents seem to bring to the helping relationship residue from their own history of relating. They are likely to experience and react to the program based upon these models, many of which are maladaptive. Trying to understand and deal with these issues in order to positively influence their model of how to be with others, including their child, is a crucial task.

## Empathy In Relationships

Looking at relationship disruption is a fairly crude way of measuring the quality of the relationship. There are other ways of measuring the relationship, although they, too, are imperfect windows onto this part of the program.

One way, of course, is asking the participants what they thought of their service provider. In the second investigation of relationships in the Memphis Nurse Home Visiting Program (Korfmacher, Kitzman, and Olds 1998), I decided to specifically study the empathy hypothesis mentioned earlier: Is felt empathy from a helper to a parent in and of itself strong enough to have a ripple effect to the mother's own developing relationship with her child? Mothers were asked at the end of the study to rate the quality of the relationship they had with their nurse home visitor, using an inventory developed by Kathryn Barnard (1998) and colleagues. This measure included items regarding the mother's perception of trust, understanding, acceptance, and sensitivity from the nurse. These items were combined to create a summary measure of nurse empathy. As noted earlier, mothers' empathy towards children was measured at the end of the program using a self-report measure.<sup>6</sup>

<sup>6</sup>In addition, mothers' responses to the same measure recorded at the *beginning* of the program were entered in analyses to statistically control for the possibility that that mothers with high levels of empathy for children may simply be more likely to perceive empathy from their nurse.

Results showed that nurse empathy did predict levels of maternal empathy, but only for some mothers: those with high levels of psychological resources, such as intelligence, emotional well-being, and mastery. For this particular home visiting program, a minimum level of psychological resources

seemed necessary for mothers to be able to respond to emotional concern and care from their nurse in a way that would influence their care towards their own child. Why this is so is unclear, although there are a couple of possibilities.

First, case studies of parent-infant psychotherapy programs that *do* demonstrate this corrective experience with low-functioning families may last even longer than the Memphis program. For example, the Clinical Infant Development Program reported cases that lasted five or six years (Greenspan et al. 1987). This length of time may be needed for the relationship to be used in this particular way for lower-functioning families. Perhaps lower-resource mothers accept empathy and support in the context of using nurses to get their more basic needs met. This focus on basic needs does not allow for a shift to positive attention to their own child. Second, the nurses themselves, who are not trained psychotherapists, are also juggling all the demands of the protocol, so they may not be working with the relationship in a manner that promotes empathic caregiving, particularly with lower resource moms who seem needier in other areas. Home visitors who focus more exclusively on emotional qualities of caregiving and the development of a therapeutic relationship may create a corrective empathic experience that is more general than that seen in this study.

## The Meaning of the Relationship

Together, these strands of research suggest that spending time with a client is not the same thing as showing that one really cares. Or that it is not enough to care. Or that we need to have a better understanding of what it means to really care. One problem is I am making conjecture here. These are reasonable assumptions (at least I think they are), but when one uses single numbers to stand in for the entire complexity of helping relationships that develop, ebb, and flow over a the course of one, two, or three years, something gets lost, and we are left with fairly tenuous conclusions. Although I had large amounts of data at my disposal, I felt as though I was losing sense of the *meaning* of these interventions—and specifically, of the relationship—to the families who participated and the providers who served them. So, after spending much time with simple ratings from large datasets, I decided to go back to the beginning and look in-depth at the helping relationship over a smaller number of cases, to try to understand how the relationship changes over time, how the different invested parties (i.e., clients, providers, researchers) view the relationship, and just what

<sup>7</sup>Doulas provide support to parents during pregnancy, labor and delivery, and the immediate postpartum period. This research is funded in part by the Spencer Foundation and by the Harris Foundation, although the views expressed are solely those of the author. Some preliminary results have been presented. (Korfmacher and Marchi 2001)

motivates people to be in these sorts of programs anyway.

To that end, I have been interviewing clients and providers across different types of programs—infant mental health, paraprofessional home-visiting, and doula—to get a sense of how the participants think about and view the relationship in their own words.<sup>7</sup> At each program I have attempted to interview a group of providers about three or four families in each of their caseloads and to interview the parent clients as well. The participants are interviewed multiple times over the course of the program, to allow them to reflect how the relationship has changed over time. These interviews are fairly open ended, asking general questions about:

- how the participant views their time together
- reasons for the client to be in the program
- how the parties handle disagreements or conflicts
- perceived similarities and differences between the mothers and clients
- ways that other family members help or hinder the parent’s participation in the program.

Although these interviews continue to be collected and analyzed, some trends are emerging. As expected, service providers with different professional orientations use very different language when talking about the relationship, and they think about the relationship in very different ways. For example, the following responses from a paraprofessional home visitor, a doula, and an infant mental health psychotherapist all involve the provider thinking about how they know their client is engaged in the program. The paraprofessional home visitor focuses on comfortable familiar feelings that she has with a teen mother.

*PARAPROFESSIONAL: [I]t’s very comfortable. I feel relaxed when I’m around her. I’m not nervous. I feel like I’m home....So we have a good relationship, and I like that because it’s like family oriented. I’m like, “OK, I have another family.”...It’s like I’m going to some of my relatives’ house. That’s how the relationship is with her...she calls me when I don’t visit. And she comes to the office and bugs me, and I’ll be like “Girl, leave me alone!” I like it because she makes me smile. I like her a lot.*

The doula focuses on the client's willingness to seek her out for information about physical symptoms during her pregnancy:

DOULA: *I believe she's starting to trust me more because her mother will come up the stairs [and say] "Natalie have a discharge," and I'll look and say, "Okay." And Natalie would just look, look at her [mother] weird, and say, "Why did you tell her that?" So now Natalie calls me and says, "You know, I'm having a discharge. What do you think it is?" Or this and that. So now, it's like I believe the trust is going.*<sup>8</sup>

<sup>8</sup>The client's name has been changed to preserve confidentiality.

Finally, the psychotherapist focuses on decreasing signs in the client's resistance when talking about how the client sometimes laughs at her in a dismissing way.

THERAPIST: *[I]f I asked her a question that she was glad to be asked but also kind of incredulous that it mattered. So like: "How are you thinking about that?" ...I think as much as she liked me to wonder about that, she couldn't believe that I really cared...[S]he would start laughing and rolling her eyes. And I think that she always feels so humiliated and she does a good job of pushing people away and humiliating them. But in the last few sessions that has really changed dramatically and she has not been doing so much laughing or eye-rolling at all, and in the past session it was the first time in a long time that she did not mention not coming back.*

For me, a particular challenge lies in recognizing my own biases when reviewing the transcripts. For example, if a paraprofessional home visitor views a client "like a daughter," or says that she would not mind going to clubs with a client, my therapist alarm goes off. From my background, such statements are boundary violations—to be discussed, contained, transformed into more "appropriate" professional-client interactions<sup>9</sup>. But paraprofessionals are not therapists, and those that I have talked to and interviewed approach the families the way that makes sense to them—as a concerned neighbor, or a secondary maternal figure, or a friend. Is this a good strategy or a problematic one?

<sup>9</sup>Indeed, in their interviews, I have noticed that therapists might say the client views them as a family member, but they rarely note that they have these feelings themselves.

It depends. Some of the interviews, for example, suggest that it is the committed, family-like focus on the client that can involve her in the program and make her feel successful. I started this paper with a quote from an interview with a teen mother who initially had very little to say about the value of a para-

professional home visiting program in which she participated. Here is a quote from the same person approximately one year later, as she discusses her home visitor:

TEEN MOTHER: *[She] ran my case a lot, like “Do right,” “Go to class,” and now she don’t have to tell me to do that because I know that these are things that I want to do for myself. I want to get into a good school, make something out of my life, you know. And she just motivates me now. You know, it’s not like she’s preaching to me all the time; she’s praising me, motivating me, ‘cause I’m doing good. I’m waiting to get accepted into college, and (she) was just proud of me for all that...I don’t want nobody else to work with me and my child but [her].*

There has obviously been a turnaround in the relationship. The client is now fiercely devoted to her home visitor, whom she sees as instrumental in keeping her motivated and involved in her child and in school. In this case, the home visitor’s lecturing or nagging (like a grandmother would do, this client initially noted) became a motivating force for the young mother.

But what of a client who struggles and is failing? A repeated theme in the interviews is that when a client had trouble staying in school, or became hard to find, the paraprofessionals took this failing very personally and reacted in kind. In these cases, a personal orientation to the helping relationship became more limiting:

PARAPROFESSIONAL: *I know I did what I was supposed to. I did the home visits, and I had started the activities with the baby....When she had the baby, I went out to the hospital to visit her...so I did my part. But it’s just that she didn’t do hers. She didn’t keep up with her part.*

PARAPROFESSIONAL: *I just tell her, “I’m just gonna block you out!” And that’s the way things going with me and her. Until she really gets herself back into school, I think me and her gonna be like that.*

Helpers bring themselves to the relationship, and it is very easy to respond in a way that is complementary to the client’s expectations. This is fine for families that can readily engage in working alliances. When the client is motivated, it motivates the helper. But for clients who have difficulty forming relationships in meaningful ways, the work of intervention is considerably harder. Paraprofessionals are not psychotherapists (neither are nurses, doulas,

or childcare workers) and so need to approach families in the way that makes sense for them. But challenging old models and ways of relating takes a great deal of reflection and purpose. How paraprofessionals (or, in fact, any other type of helper) do this while still retaining a sense of who they are—a genuineness of self—is the point on which the relationship turns. To do well by difficult clients involves more than being available and reaching out. Helpers need to be actively thinking about how to connect with these families.

## Conclusion

The early childhood interventions that I have studied do many things. They provide practical information to parents. They link them up to needed services. They provide a model of success and of problem solving. But they can also provide something else that is more intangible. They can give a sense of scaffolding and security to the participant. And by doing this, they can nudge the developmental pathway of infants, parents, and the whole family. I firmly believe that to be in a good program can be a transformative experience. And understanding the nature of the experience is crucial. This involves getting at the meaning of the intervention to the individual. What it means to participate in an intervention, and how participation can motivate families to do well, is the very heart of what it is we are trying to study.

In other words, it depends. We are a long way off from singing and dancing academics, united by common beliefs and findings. There is a strong need to move from yes-or-no questions regarding whether an intervention for parents and young children works or not to seriously exploring what occurs inside and around an intervention. Such explorations can be beneficial to a field that is feeling increased pressure to “fix” problems of at-risk populations before other service programs have to deal with them at later stages of development. The avenues of exploration promoted here will not simplify the field. We can instead expect more complications and debate. At the same time, however, such explorations will provide much-needed information. We now have considerable evidence from the last 30 years that asking limited, “what works” questions can only produce limited conclusions. Although understanding the nature of the intervention experience will not provide the simple recipe of success for all families who participate in these programs, it can provide understanding as to why there is success for some and how there can be success for others.

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The Herr Research Center, established in 1997 with a gift from the Herr family, is the hub of research activities at Erikson Institute. Its mission is the development of knowledge from applied research that contributes to a significant improvement in the quality, effectiveness, and equity of education and services for children and families. The center provides technical assistance and funding for the development and implementation of a wide variety of research projects, promotes the dissemination of research findings, and sponsors conferences and seminars.

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