

THE HEART OF RELATIONSHIP-BASED CARE

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How can one understand the experience of those who participate in early childhood programs — both the families who enroll and the staff who provide services? Robert Emde once wrote that what is important about an intervention is its meaning to participants.

Meaning...refers to how an individual experiences a set of events. It involves perception, feeling, and an interpretive act; it involves the use of one's past experience and an evaluation of whether the event is familiar or novel, pleasant or unpleasant. (*Emde 1988, p 257*)

What is the meaning of early childhood support services to the family? For many families, the experience will be a novel one, in that they likely have not participated in this type of service before. They will, however, attempt to put it into the context of other supportive (or unsupportive) experiences they have had. They will think about the help they have sought and received at other times, either formally through public or social services, or informally through friends and family members. And most likely, they will think about the person who gave them assistance, or the person they could not count on.

What is the meaning of the intervention to the actual service provider? Providers have a greater baseline of experiences upon which to draw when making meaning of the time they spend with a family — former clients they have helped, or families who proved elusive to assistance. They also unavoidably bring their own personal history into the mix — their memories of times when someone came through for them, or their own biases of what is the right or wrong course of action when they witness a particular family dynamic unfold. This perspective might be filtered through the particular philosophy or curriculum of the program model they currently find themselves working under, but it is the providers' own understanding of the program model that matters.

The provider and the parent bring their interpretive acts together as they work with each other, in the relationship they form with each other, influenced (in part) by the relationships they have already made. It is here, at this intersubjective point of convergence, that a new meaning emerges. Fundamentally, the meaning of the experience depends on the quality of the relationship that forms between the family member and the provider, and how this relationship intersects with other relationships in the family's life.

As should be obvious to readers of this newsletter, early childhood is swimming in relationships. Although the invisible thread between the parent and the child may be central, this relationship exists in a web of other relationships, including relationships with the baby's social or biological father and with other important family members, such as the baby's grandparents.

When we say that an intervention is "relationship-based," we mean that it pays attention to this central relationship, and that it becomes part of this web of relationships (see Weston et al. 1997). The provider forms an alliance not just with the mother, but also with the child and other family members. Many early childhood programs recognize the centrality of the helping relationship and note its importance as part of the work that is done with families. I had noticed in my work, however, that relationship-based care had become a kind of shorthand to describing a program's philosophy — often so short that the usefulness of the phrase became questionable (as my colleague Zack Boukydis has noted, lots of unfortunate events also occur in the context of relationships). So perhaps it is time to spend some time unpacking relationship-based care.

What is the purpose of the helping relationship?

There are different ways to think about the purpose of the relationship. The helping relationship can be facilitative, in that the relationship is primarily the means to an end. In other words, the provider might be thinking, "If I form a good relationship with the family, they will trust and listen to me and take my advice." This perspective reflects the medical model of relationships. The relationship can also be considered a goal-oriented partnership. In this case, the provider and the parent work together around setting goals for the child, with the relationship primarily defined by a sense of accomplishment in reaching these goals. This approach is often assumed in early intervention programs for children with specific delays or disabilities. Although there is a greater emphasis on mutuality than in a purely facilitative relationship, the focus is largely on fixing some problem or meeting a specific goal.

The relationship may be supportive. The provision of emotional (and practical) support within the context of a caring relationship is designed to reduce any stress and isolation experienced by the parent, helping her to better meet the needs of her child.

Classic grassroots family support programs tended to emphasize this orientation to relationships (see Halpern 1999, for review). A relationship may also be considered corrective — a nurturing relationship will help the parent to experience a sense of security and empathy that she has not felt before, thereby correcting old models of relationships and helping her to be more empathic to her own child's needs (see Lieberman 1991). This approach can help the parent see and feel new ways of relating and can be summed up with a variation of the Golden Rule expressed by Jeree Pawl (1994): Do unto others as you would have others do unto others. This perspective of relationships is closely aligned with the infant mental health orientation.

These approaches to relationships are not mutually exclusive, so that a helping relationship can contain some or all of these elements (see Fraiberg et al. 1980, for example). Nonetheless, it is not unreasonable to infer that one's emphasis on what to accomplish in the relationship will play out in the actual strategies or experiences shared with the family.

Measuring the relationship

The helping relationship in early childhood programs, when it has been studied, has typically been assessed using paper and pencil measures. These measures are usually Likert-type scales with statements to which the respondent indicates some level of agreement (e.g., "My home visitor is someone I can rely on.") that are then summed for a total score. There are two major problems with these rating scales: they are reductive and skewed. They are *reductive* in that you take a living, breathing phenomenon, strip it of all context, and summarize it with a few simple numbers. This reality plagues all rating scales, but the existing measures of helping relationships are particularly prone to this shortcoming.

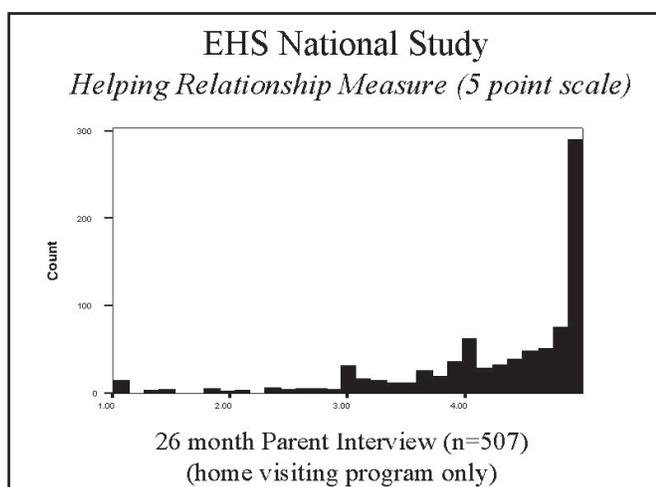


Figure 1.

No matter how many aspects of the helping relationship a measure attempts to delineate (like Empathy, Working Partnership, or Cultural Sensitivity), what often emerges is one general category of good stuff. Essentially, families are asked whether or not they like spending time with their home visitor, with little nuance to the results (Korfmacher et al. in press).

Helping Relationship rating scales are *skewed*, meaning that most of the time you get very little range in responses. Respondents almost always give the relationship very high scores, even if there is little or no contact between parent and service provider. For example, the national study of Early Head Start used a helping relationship measure in which the majority of over 500 parents gave their home visitor the top score for *every* question (see Figure 1, from Korfmacher et al. 2004). Whatever the reason for this tendency (see Korfmacher et al., in press, for more discussion), one ideally wants a measure that captures the whole range of experience, good and bad, in a service program.

Paper and pencil tests, then, are limited in their ability to truly explain these relationships. As I began to consider other ways of discovering how people perceive the helping relationship in early childhood programs, it occurred to me that perhaps I should just ask them. So that is what I did, using semi-structured interviews that allowed for a more in-depth examination of participant thoughts and feelings.

So far, I have studied the helping relationship in-depth across three programs. The first was a family support program for pregnant and parenting teen mothers run through a large urban public school system, using part-time paraprofessional home visitors from the community, called family advocates. Their role was to help mothers stay in school, prevent future pregnancies, and promote the cognitive and social-emotional development of their infants and toddlers (see Korfmacher & Marchi 2002).

The second program was an intervention, also for young mothers, using community-based doulas who met mothers at home or in the clinic. Doulas are non-medical helpers who provide emotional support and physical comfort during labor and delivery (Klaus et al. 2002). Although there is variation in how doulas define their role and in their previous professional experience, the doulas under this particular model could be regarded as quasi-paraprofessionals; they did not have professional degrees, and were hired because of their similarity to the young mothers they served, but they received extensive training for their role, both initially and during the course of the intervention trial (Behnke & Hans 2002). The model itself was an expanded one, going beyond the birth experience, by recruiting mothers during the second trimester of pregnancy and continuing with them until the child was three months old. This approach was assumed, in part, to facilitate a close working alliance between young mother and doula (Glink & Altfeld 1999).

The third program was a mental health center with programming that focused on serving young children in Chicago. The participating therapists were mostly social workers who served families with children less than five years of age who came or were referred to the clinic for social-emotional, behavioral, or relationship-based disturbances.

For the first two programs, both the providers (family advocates and doulas) and the mothers were interviewed about the relationship they had developed with each other. For the community-based mental health program, only the therapists were interviewed. Although each set of interviews was conducted as part of a separate study, I had in mind that they were opportunities to explore how different providers form relationships with families and how they think about these relationships. Consequently, the interviews were designed to be as similar to each other as possible to allow for this comparison.

Interviews were conducted multiple times (from two to four times). Each interview was between 30 and 60 minutes in duration, and all were recorded and transcribed. The interviews had specific areas of focus, but much flexibility allowed for individual follow-up. Areas of focus included the mother's motivation for joining the program, initial impressions each party had of the other, their description of the relationship, how the relationship changed over time, similarities and differences between the parent and the provider, the involvement of other family members, conflicts and disagreements (and how they were resolved), and ways in which the parent experienced the provider as helpful. The transcriptions were subjected to content analysis (see Patton 1987). A coding system was developed and refined based on themes and patterns that emerged from the interviews. For each dataset, I and another coder reviewed transcripts individually, then arrived at consensus in regular meetings and discussions.

Themes from interviews

Although space does not permit exploring all the themes that emerged from these sets of interviews, I will focus on three inter-related issues: the personal versus professional relationship, the role of love and intimacy in the helping relationship, and the costs associated with a personal relationship.

1) The personal relationship. Paraprofessionals and doulas both tended to view the relationship in explicitly personal terms. They used friend and family designations to describe the alliance. One doula used the term "Auntie Doula" to describe herself to clients, in order to suggest that they should view her as an elder family friend. These providers also talked of a sense of comfort and familiarity when the relationship went well.

Family Advocate: I can go and I can sit back and you know, I can sit back and we can just talk. And then sometimes after, we find ourselves on a totally different subject. And I'm like "Oh girlfriend, you be doing my part and get over here so we could

do this." So it's like so comfortable and relaxing. So the times spent with her it's like I could sit and hang with Tammy.

Doulas and paraprofessionals talked of the need to make parts of themselves available to the mothers. In this way they could provide a different experience than that offered by other, more professionalized service providers.

Doula: I think the more clients I get to, the more I realize you have to give a little to get from them. So sometimes you are sending a little piece of yourself. You have to share to let them realize that you are not an alien, you're not by yourself, there's someone that understands.

They revealed personal aspects of their lives — often giving out their home phone numbers, talking to the mothers about their own teen years, or using terms of endearment such as "sweetheart."

Doula: I said, you know, I went through the same thing when I was pregnant as a teen. I said, and it's nothing to be embarrassed about, and that's when she looked at me...

For their part, mothers in the doula and paraprofessional programs also noted how much the relationships could be viewed in personal terms, as these quotations (from the paraprofessional program) demonstrate:

Young Mother: She just took me in just like...I feel like she's a second mama, I'm like a second daughter to her. She'll call me. She'll say everything..."Girl, guess what happened?" I say "What happened, momma?" We just talk.

Young Mother: Um, like a friend, you know, like a close friend but also like a mother-daughter thing, you know, a grandmother kind of thing.

To some extent, this personal relationship contrasted with the sense of professionalism that the service providers were striving for. Doulas and paraprofessionals would occasionally note the tension in interviews:

Family Advocate: I'm trying to keep it sort of balanced. I want to be there. I want to be your friend, your mother, whatever you need me to be. But I don't want to overstep my professionalism either.

The doulas in this study were hospital employees, and wanted to be viewed by the medical staff as valuable contributors to the birth process. Maintaining this identity while forging a personal connection to clients was particularly important. In wrap-up surveys completed after finishing with each client, doulas noted that forming relationships with the young mothers was both what they felt most successful with *and* most challenged by.

In contrast to the paraprofessionals and the doulas, the mental health therapists rarely discussed having a personal relationship with families, except in cases where they noted clients felt that way about them.

Therapist: In her becoming comfortable with me, she's becoming afraid and that the closer you get with somebody, maybe the more likely you would want to discuss deeper issues, and that she still is resistant against wanting to go any deeper so she's kind of keeping me at a friendship arm's length or distance.

For this therapist, being seen as a friend is actually limiting, a way to avoid having the relationship go to a deeper level. Therapists did talk about whether or not they liked a client, whether they felt a genuine connection to the parent or family member. But at the same time, it was being balanced by what they had learned from their professional training — is the relationship productive or at least consistent with what my training says a good therapeutic relationship should be?

Therapist: She started to become very interested in details about my life, who I am, do I have children... I think I'm becoming a person to her. ...[but] I'm negotiating that, because... basically she's the focus of the treatment and I want to be most helpful to her. Basically the reason why we may not be talking about my own personal information is that it may take up too much space and then the focus would be on me, and I really want the focus of treatment to be on her.

Getting too personal is a way of avoiding why the client is there with the therapist — to work on the mother's relationship with her child. Contrast this with the doula's statement that you have to give a piece of yourself to be able to work with the mothers.

2) Intimacy and Love. With familiarity comes intimacy, and this was certainly true in many of the relationships that were the focus of the interviews. Early childhood evokes a sense of intimacy, and this is intensified by home visiting, as providers are visiting families where they live. Doulas, in particular, are privy to one of the most intimate experiences in a young woman's life — the birth of her child. The following paired quotations, from the mother and her doula, about the mother's delivery experience, demonstrates this intimacy:

Mother: ...I've been knowing her for the longest and that's just how we communicate, but she's just like a friend. We've been through like everything. Labor was really hard, but she was there for me though. I actually asked if she would be my baby's godmother. That's because I feel that close to her now.

Doula: It almost made me go against my big rule [to] never cry. And I was just like okay, I just couldn't believe it, and after everything was over she hugged me so tight and she says, "I love you." And I said, "Oh I love you."

Noteworthy is the doula's recounting of her feelings during the experience, especially the use of the term "love." Expressions of love are generally not heard from professional providers. Yet the doulas and the family advocates would mention these feelings a fair bit.

Family Advocate: I love her like my daughter. You know, I do. I figure that whatever I have, I share, you know, I share with her? It's just that she's that type of person that you just want to put her up under your wings...

The therapists, on the other hand, were much more circumspect. When searching through the interviews for mentions of love, I encountered examples such as this:

Therapist: When I get there it seems like she's excited to see me. The kids are excited to see me. She has let me in a lot more than she did in the beginning but she uses me and she uses the treatment to talk about things that are going on with her...I like her a lot. I like to be in the house. I love to be around the kids. I love to be around her. I enjoy the relationship that we have.

This is not really an expression of love towards the client, but an acknowledgement of the positive feelings that the therapist has towards the family that leads her to want to spend more time with the mother and children.

Love can be defined in different ways. Some aspects of love (such as romantic longing) are less relevant to family-provider relationships. But love also encompasses platonic components (based on admiration or common interests), kinship or fraternal ties (even without a direct blood relation), and benevolent concern for another (a calling to do good for others). This latter form of benevolent love often has roots in deeply held religious or spiritual beliefs. Platonic, familial, and spiritual love play out in the relationships that I have interviewed mothers and providers about. The interest, concern, and deep commitment providers have for families lends itself to feelings of love, particularly when the provider has a more personal view of forming relationships with family clients.

3) Costs of the personal relationship. What does it mean to love your client? With love comes an intensity of emotions — some are very positive, such as a joyful crying together, or smiling about a family when a provider thinks about them. These deep reservoirs of feeling can make the client feel very special and supported and make the provider feel energized about their work.

But what happens when those emotions are not so positive? This personal connection and these deep feelings that can keep a young mother connected and engaged in the program when things go well can create major roadblocks to progress when things do not go so well. Difficult reactions can emerge when

feelings in the helping relationship are personalized. The risk to forming a strong personal connection to clients is that it can be disappointing when clients do not react the way you expect. As one doula noted:

Doula: When you get so up close and personal you have to really put yourself out and give back and realize they're going to do what they want to do.

When asked what she had done that had been most helpful for this young mother, the doula said it had been acquiring a soft infant carrier.

Doula: [W]hen you think that you've made an impact on them, that might not be the impact. It might be for you but not for them. When I saw her I said "Man, I thought I was really getting down with her," but I've never seen no expression like that coming out of her...It wasn't my doing. It was the carrier. She really needed it at the time. But I think that's what makes a difference.

The doula acknowledged the benefit of being able to do something helpful for the mother, but the sentiment was mixed. Given how attached the doula was to the mother, it did not feel like enough — she wanted more success and to feel that her outreach to the mother was appreciated. Instead of being able to celebrate the help she could give the mother, she felt disappointed.

A related negative feeling that can emerge in the context of a personal relationship is the sense of being taken for granted. The providers and the clients both noted this feeling in interviews, as this quotation from a young mother in the paraprofessional program demonstrates:

Young Mother: She'll go visit [other clients] before she go visit me, 'cause she thinks I'll understand 'cause I know how sometimes they get busy. And I feel like, no, I won't understand.

The family advocate, in her interview, initially noted that one of the benefits of having a close relationship with this teen mother was that she knew she could get away with skipping visits with the mother and her child. The personal relationship, in other words, was used as a rationale to limit professional obligations. This assumption became a major source of contention between the two of them, almost derailing their work together until the mother herself confronted the family advocate with her feelings, and they then worked it out.

Another repercussion of the personal relationship is that providers may take the client's problems personally. They react to setbacks in the life of the client as a friend or a family member might, not as a helper whose job it is to support them in their challenging times.

Family Advocate: It really hurt me that she wasn't back in school. Because I felt like our relationship was much better than that...The beginning, I was happy to know she was my client. She was the happy client. And now, I just get frustrated because she's not in school, she's not working. She's getting lazy. And it really pisses me off actually, you know? Because it seems like she's going backwards when she needs to be going forward.

Taking their problems personally led to feelings of anger and disappointment towards the client, and to feelings of rejection. Sometimes the family advocates admitted to an almost righteous anger when disappointed by the mothers in their caseload. The cases noted in both of the quotations that follow were mothers who dropped out of school. The sense of betrayal the advocates felt is palpable. The mothers really let them down and the advocates had a hard time coming back from that.

Family Advocate: If I put a little authority in my voice, she did it...I had come over and the baby's pampers would be soaking wet. So I'm like, "Tammy, what's going on?"...And I say, "Get up off your ass and put 'em on a pampers!" And that's how you have to talk to her.

Family Advocate: I just tell her, "I'm just gonna block you out." And that's the way things are going with me and her. Until she really gets herself back into school, I think me and her gonna be like that. I think, we're not really drifting apart in the client and the family-advocate way. We're drifting apart in the mother and daughter way.

As these examples show, the personal relationship influenced how the providers dealt with the conflicts that arose. Sometimes the providers would simply avoid the conflictual issue:

Family Advocate: She always ask me... "Why you don't give me no opinion?" "Because for one reason. If I give you an opinion and it's wrong, then, you're gonna dislike me because you're gonna say, '(She) gave me the wrong opinion.'"

Providers have to pick their battles, so there are many occasions where families take an action that a service provider may not be thrilled with, but is willing to let go in order to focus on more pressing issues. The quotation above, however, highlights an example where the home visitor did not want the mother to dislike her. This concern over being liked or not suggests that personal concerns can be driving the interactions, not professional ones.

Doulas, on the other hand, would typically try to work out the disagreements with the mothers, but then leave it alone if they could not make progress. The doulas viewed this strategy as an important aspect of their relationship-development with the young mothers, treating their opinions with respect when other providers the young mothers worked with may not. For example, breast-

feeding was a particular source of conflict between doulas and the young mothers (Korfmacher, in press). Although the doulas were very committed to breastfeeding, they knew this was a difficult topic for this population of young, African-American women. So they pushed it, but also knew when to leave it alone.

Mother: That's the only thing we disagreed about...I didn't do it, I didn't want to go through it...I was just like hm, hm, hm, hm, hm, hm. I listened to her, and I'm like I'm still not doing it. And you know she finally accepted the fact that this girl has made up her mind.

Doula: Right and she didn't [breastfeed]. So it was never like an issue with me because in the back of her mind, it's ultimately her decision. I'll just give you an opinion.

In contrast to both the doulas and paraprofessionals, the therapists were more likely to view conflict and the expression of disagreement positively, as a sign that the family was engaged in treatment. The therapists, in general, were more willing to work with the conflict. The following is an example of this, with the therapist wanting more expressed anger from the mother:

Therapist: Now at times she'll cut me off, by for example having a long phone conversation in the middle of a session or having her best friend present. She'll titrate the emotional intensity of a session...I feel like when she communicates something in a more hostile way or a more up-front way then we can address it in a better way.

Implications

Contrasting examples from paraprofessionals and therapists should not imply that paraprofessionals need to be more like therapists. But it does reinforce the reality that providers with different backgrounds have different ways of thinking about the relationship. These definitions of the helping relationship and the influence of the various definitions on actual practice should be a major focus of research and practice. For example, is it ever appropriate for a provider to express anger? Maybe a paraprofessional who chastises a young mother for having an infant in a soiled diaper can be more effective than a therapist who maintains a professional distance. The real and genuine expression of emotion has been advocated even in therapeutic relationships (e.g., Rogers 1951), and its place in early childhood

family support programs is important to consider. What is the distinction between loving a client and having genuine positive regard for the client?

But real feelings need real thought behind them as well. It became readily apparent in the interviews with the paraprofessionals that they were often getting little supervision or support in their work. This reality led them to approach the relationships in a reactive fashion. Both the doulas and the therapists received weekly individual supervision and met regularly for group supervision as well. The importance of regular supervision as a place to think about oneself in the helping relationship seems important, and it seems something that could have benefited the paraprofessionals. For example, at the end of the interviews, providers were asked what they had learned about themselves in the course of their work in their program, and the following quotation from one of the family advocates suggests the potential for reflective practice:

Family Advocate: I see things how I wanna see them and how I want them to go...So when something happens, it's like a setback...I just assume the way I want it, that's the way that they wanted it. So now, I have to learn to accept change. I have to learn that everybody is different...It changed me and let me see, "You are not always right." You have to learn from these kids too because they are trying to tell you something. You just aren't listening.

If it is important to have a personal connection with their clients, how can providers use this connection in a way that is helpful? How do they demonstrate a sense of professional development without losing the personal qualities that might have led to their hiring in the first place? Reflective practice is not a panacea for difficult moments or role confusion, but it can provide a way for providers to be both real and deliberate in the time they spend with families.

Acknowledgements

This project was funded by grants from the Spencer Foundation, the US Maternal and Child Health Bureau (No R40 MC 00203-04), and the Irving B. Harris Foundation. I would like to thank the following for their contribution to data collection, coding, and analysis: Isabela Marchi (paraprofessional study), Marisha Humphries (doula study), Bonnie Schwartz (infant mental health study). Portions of this manuscript were adapted from a previous publication (Korfmacher & Marchi 2002).

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