Chapter 1: Introduction and the Social Problem: Child Abuse and Neglect

The tender years of early childhood offer great promise and challenge. All children are shaped by their early life experiences. Children grow optimally in safe homes and communities with nurturing, dependable and attentive caregivers (Miranda, Arthur, Milan, Mahoney, & Perry, 1998). Children who experience enriching environments view the world as a safe, exciting place to learn and explore, where adults are available, responsive and able to meet their needs (Delaney, 1998). These positive early life experiences stimulate a child's physical, intellectual, social, and emotional development thereby increasing chances for health, happiness, productivity, and creativity. Many children, however, do not have these opportunities as a result of maltreatment.

Definitions of Terms

To further a discussion on child maltreatment, clarity of terms is needed. For the purpose of this discussion, child abuse will be used to represent all forms of child maltreatment. Legal definitions can be found in the Child Abuse Prevention and Treatment Act of 1996. At a minimum, child abuse is defined as an act or failure to act on the part of a parent or caretaker which presents an imminent risk of serious harm or results in death, serious physical or emotional harm, sexual abuse or exploitation (Toni, 2006). The National Clearinghouse on Child Abuse and Neglect Information (2001c) provides the following elaboration for clarification:

Physical abuse: the infliction of physical injury as a result of punching, kicking, biting, burning, shaking or otherwise harming a child. The parent or caretaker may not have intended to hurt the child; rather the injury may have resulted from over-discipline or physical punishment.
**Child neglect:** failure to provide for the child’s basic needs. Neglect can be physical, educational, or emotional. Physical neglect includes refusal of or delay in seeking health care, abandonment, expulsion from the home or refusal to allow a runaway to return home, and inadequate supervision. Educational neglect includes the allowance of chronic truancy, failure to enroll a child of mandatory school age in school, and failure to attend to a special educational need.

**Emotional neglect:** includes such actions as marked inattention to the child’s needs for affection, refusal of or failure to provide needed psychological care, spouse abuse in the child’s presence, and permission of drug or alcohol use by the child. The assessment of child neglect requires consideration of cultural values and standards of care as well as recognition that the failure to provide the necessities of life may be related to poverty.

**Sexual abuse:** fondling of a child’s genitals, intercourse, rape, sodomy, exhibitionism, and commercial exploitation through prostitution or the production of pornographic materials.

**Emotional abuse:** acts or omissions by the parents or other caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders.

Greater attention has been paid to another form of emotional neglect: the witnessing of domestic violence. The National Clearinghouse on Child Abuse and Neglect Information (2001b) details three of the risks faced by children living in domestically violent homes: the risk of observing traumatic events, of being abused themselves, and of being neglected.

Domestic violence is a pattern of assaultive and coercive behaviors by adults or adolescents used to intimidate their partners (National Committee to Prevent Child Abuse, 1998). But, domestic violence also impacts the children in the family. A child may be threatened or harmed by an abusive partner as a way of punishing or controlling the adult victim of domestic violence. Also, a caretaker who is being demeaned, degraded, enraged and terrified will likely have diminished parenting ability. Domestic violence victims can be unresponsive to their children due to their own fears or neglect
the children in their vigilance to their abusive partner (National Clearinghouse on Child Abuse and Neglect Information, 2001b). Conversely, some parents over-discipline to control the child’s behavior in an attempt to keep them from greater abuse from their violent partner (National Clearinghouse on Child Abuse and Neglect Information, 2001b).

Since the witnessing of domestic violence is generally not included in other child maltreatment statistics, it requires a bit more elaboration. Domestic violence is a significant problem estimated to occur in 2-3 million American households and in 20-30% of marriages (Acierno & Resnick, 1997; Maker & Kemmelmeier, 1998). This results in an estimated 3.3 million children between the ages of 3 and 17 witnessing a violent incident involving their parent each year (National Committee to Prevent Child Abuse, 1998). Often episodes of domestic violence expand to include attacks on children. Even when not physically harmed, domestic violence impacts children by terrifying, traumatizing, and sometimes depriving them of mothering (National Clearinghouse on Child Abuse and Neglect Information, 1998a). In the U.S., male partners kill 1,700 women each year (Maker & Kemmelmeier, 1998).

*Incidence of Child Maltreatment*

Child maltreatment continues to be a substantial social problem in the United States. Confirmed child fatalities from child maltreatment have increased in both number and rate over the last five years (U.S. Department of Health and Human Services, 2009). The National Committee to Prevent Child Abuse (2001) concluded that five children died on average each day in the U.S. as the result of child maltreatment (National
Clearinghouse on Child Abuse and Neglect Information, 2001a) An estimated 1,760 children died as a result of maltreatment in 2007 (U.S. Department of Health and Human Services, 2009) Given its occurrence, child maltreatment maintains a place with other major public health threats such as AIDS (Wolfe, 1993).

U.S. child protective services agencies investigated 3.2 million reports alleging the maltreatment of 5.8 million children in 2007 (U.S. Department of Health and Human Services, 2009). In that same year, approximately 794,000 children were victims of abuse and neglect in the United States (U.S. Department of Health and Human Services, 2009). The majority of these cases (59%) were due to neglect. The perpetrators of child maltreatment are predominantly parents (79.9%). They are presumably more likely to be mothers since 56.5% of perpetrators are female (U.S. Department of Health and Human Services, 2009). There were 1,760 child deaths formally attributed to maltreatment in 2007 (U.S. Department of Health and Human Services, 2009). Sadly, these are very young children; 75.7% of these children were under four years of age (U.S. Department of Health and Human Services, 2009). Almost half were under a year old and most (69.9%) died at the hands of their parents (U.S. Department of Health and Human Services, 2009).

In 2007, at least one child was found to be a victim of child maltreatment in 25.2% of child abuse investigations (U.S. Department of Health and Human Services, 2009). In 1996, 44 out of every 1,000 children in the US were reported to child protective agencies. Only 15 children out of every 44 were judged to be victims of child maltreatment. Hence, roughly 2/3 to 3/4 of all reported victimizations are dismissed. One could be concerned that the entire child protection system is simply one of vindictive
neighbors and custody disputes. However, over half of the reports (57.7%) were from professionals (U.S. Department of Health and Human Services, 2009). Furthermore, given estimates that 20-45% of women and 10-18% of men in the United States and Canada have been sexually abused as children, underestimating has long been the greater concern (Morrow & Smith, 1995). Estimated incidence rates of child maltreatment vary, are of questionable accuracy, and depend on the source of data. Uniform definitions across states are lacking. Incidence rates vary as to timeframe and are subject to changes in reporting laws and public opinion; but it is generally agreed that child abuse and neglect remains underreported (Belsky, 1993; National Clearinghouse on Child Abuse and Neglect Information, 2001a, 2001c; U.S. Department of Health and Human Services, 1996, 1999). The significance of child maltreatment is derived not only from its prevalence but also its impact.

**Impact of Child Maltreatment**

Beyond the impact of lost or damaged young lives, there are extensive costs from child maltreatment in both direct and indirect expenses. Direct costs are the dollars used in the child welfare system as well as the systems responding to abused and neglected children and their families including law enforcement, justice, health and mental health (Prevent Child Abuse America, 2007). Direct costs can be estimated in fairly concrete numbers such as $25 billion for child welfare agencies (Prevent Child Abuse America, 2007). For a small portion of the physically abused population -- 214 shaken baby syndrome victims identified in a 10-year period in Missouri -- expenses totaled $6.9
million or $32,500 per child (National Clearinghouse on Child Abuse and Neglect Information, 1998d).

Even more difficult to calculate are the indirect costs reflecting the long-term economic consequences of child maltreatment such as special education, mental health, substance abuse, teen pregnancy, welfare use, domestic violence, homelessness, juvenile delinquency and adult criminality. Cohen and Miller (1998) found that 3.1 to 4.7 million people were receiving mental health counseling for their victimization at a cost of $5.8 to $6.8 billion in 1991. Half of the adults in all forms of counseling were being treated for physical and sexual abuse experienced as children. Although victims represent 20-25% of the client population of psychologists, they consumed 40% of their hours of service. Furthermore, recovery by victims was slower than that of non-victims. Holmes (1995) found that patients who showed the most improvement were those least likely to have been abused as children. Conversely, patients who showed the least improvement were most likely to have an abuse history. When looking only at depressed patients, those with abuse histories showed less improvement than those equally depressed with no history of abuse (Holmes, 1995).

The costs of child maltreatment are tremendous. A 1996 National Institute of Justice Study estimated the victim-related tangible and intangible costs of violence against children (excluding child neglect and justice system costs) exceeded $164 billion annually for the years 1987-1990 (Miller, Cohen, & Wiersema, 1996). For New York State alone, the costs of hospitalizations due to child maltreatment are $10.4 million annually (Nobuyasu, 2001). Similarly, the expenses as a result of child maltreatment for special education are $9.7 million, protective services $5.7 million, foster care $3.31
and psychological problems $17.5 million in the State of New York each year (Nobuyasu, 2001). For the year 2007, Prevent Child Abuse America calculated the total direct annual costs of child abuse and neglect in the United States at $33,101,302,133 (Prevent Child Abuse America, 2007). Total indirect costs including special education, mental health and health care, juvenile delinquency, adult criminality and lost productivity came to $70,652,715,359 for a grand total of $103.8 billion (Prevent Child Abuse America, 2007).

The Impact of Child Maltreatment on Brain Development

More recently, the consequences of child abuse and neglect have been discovered in the field of neurology. Attention has been focused on the impact of child maltreatment on brain development. Technical advances allow scientists to now study children’s brain development at the cellular level. This has resulted in the startling and unsettling findings that child abuse not only results in emotional problems, but also in significantly altered physiology (Eliot, 1999; Garbarino, 1998; Karr-Morse & Wiley, 1997; Kotulak, 1996; Perry, 1997). There remains a tremendous heterogeneity of impact from childhood violence, but it is becoming apparent that experience influences brain development (Perry, Pollard, Blakely, Baker, & Vigilante, 1995). Two aspects of brain development are especially relevant: the role of experience and sequential development.

At birth, the child’s brain is the least developed organ of the human body. The bulk of brain development occurs in very early childhood. Initially, babies form many more connections between neurons in the brain than they will ever use or be able to
maintain (Thompson, 1998). The brain later eliminates those that are rarely used. In order to improve the speed with which the brain works, connections not used are slowly pruned away and those that are used are strengthened (Thompson, 1998). This ‘use it or lose it’ phenomenon allows our brains to function more efficiently and relates to Perry’s (1996) notion of “windows of opportunity.” This has long been understood in animals. For example, a mouse whose eyes are sewn shut for the first weeks of life will not see at a later age even when the eyes are opened (Wiesel, 1982). The brain connections are simply not there after this critical window of development has passed. As applied to humans, Perry contends that Mozart could never have played music had he not heard music in his first years of life.

There is enormous potential in the minds of babies, but brain development in early life becomes problematic for children growing in violent environments. Trauma is an experience that affects brain development as it produces stress in the bodies of victims (Perry et al., 1995). The hormones adrenalin and cortisol are produced when the body is under stress (Perry, Conroy, & Ravitz, 1991). Cortisol washes over the tender brain like acid These primitive fight or flight hormones cause changes in the victim such as hypervigilance, increased muscle tone, tachycardia (rapid heartbeat) and increased blood pressure (Perry et al., 1995). The more prolonged the stress, the more chronic and potentially permanent the emotional, cognitive and physiologic changes (Perry et al., 1995).

The second highly relevant aspect of brain development is the sequential development from the lowest part (brain stem) to the highest (cortex). Eventually the higher cortical areas develop and exert their control over the lower brain. For example,
the higher thought areas of an adult brain mediate the excitement of the lower regions. Hence, though frustrated adults may feel like lying on the floor, kicking and screaming, they generally do not. “The brain’s impulse-mediating capacity is related to the ratio between the excitatory activity of the lower more-primitive portions of the brain and the modulating activity of higher, sub-cortical and cortical areas” (Perry, 1997, p. 128). Hence, impulsive and aggressive responses to minor stressors can become the pattern of behavior for life if there is a lack of appropriate sensory experiences during windows of opportunity for higher brain development or if there are atypical or abnormal disruptions to normal development due to extremes of experience (Perry, 1997). Experiencing abuse or profound neglect as a child certainly qualifies as an extreme experience.

The Impact of Child Maltreatment on Attachment

Neurophysiology is intimately connected to behavior and attachment (Kotulak, 1996). Thus, a variety of mental disorders originate in early childhood trauma and attachment disturbances (Delaney, 1998; van der Kolk & Fisler, 1994). Aggression, self-destructive behaviors, eating disorders and substance abuse can be understood as attempts at self-regulation (Delaney, 1998; van der Kolk & Fisler, 1994). “Loss of ability to regulate the intensity of feelings and impulses is possibly the most far-reaching effect of trauma and neglect” (van der Kolk & Fisler, 1994, p. 145).

Emotional regulation begins with the response of the parent to the child’s behavior. The relationship between a child and primary caregiver provides the critical foundation in the development of a child and their development of close relationships and empathy. “Caregivers are toys for the brain” (Thompson, 1998, p. 6). The experiences
with caregivers help the wiring in the brain for attaching to others. Hence, brain development appears to be intricately connected to attachment (Perry, 1997). While attachments continue to be formed in later childhood and into adulthood, the fundamental patterns for these connections are shaped in the first two years of life (Karr-Morse & Wiley, 1997). The recent advances in brain research have revealed the neurobiology underlying attachment. Attachment is not a new concept but now the connection and complex interplay of nature and nurture are better understood and can be concretely observed.

Attachment has been studied since the late nineteenth century (Watkins, 1987). Broadly defined, attachment is the lasting psychological connectedness between human beings (Delaney, 1998). Bowlby (1991) described critical situations which elicit attachment behaviors such as illness, the presence of a stranger, darkness, hunger and fatigue. When caretakers respond with accessibility and responsiveness, attachment blossoms. In contrast, disruptions in attachment are followed by a cycle of protest (crying), despair and detachment. If this cycle is repeated chronically in a young life, children begin to conceive of caretakers as unresponsive, unreliable, threatening, dangerous or rejecting and themselves as worthless, unsafe and impotent (Delaney, 1998). This view of others and self can be quite pervasive, flavoring future interactions. “It appears that if children don’t learn how to trust at least one person by the time they are three or four, chances are slim that they can ever gain this essential ability” (Ramey & Ramey, 1999, p. 14).
Resiliency’s Influence on the Impact of Child Maltreatment

The capacity to form relationships, regulate emotions, and learn is formed in the early years of childhood. Change is always possible but becomes more difficult as the brain ages. Fortunately, children and adults, including their brains, are pliable. This differs from the often-used term of resiliency. Resiliency is an interesting concept but comes with difficulties as applied to maltreated children. “Children are not resilient, children are malleable” (Perry et al., 1995, p. 124). Resiliency is the return to an original shape or position while malleability involves the ability to adapt and be shaped or formed (Stein & Su, 1980). It has been proposed that so-called resilient children are simply those that have more internalized ways of expressing their reactions as in depression (Fraser, Richman, & Galinsky, 1999). Despite their less obvious expressions of anxiety and their compliance, the children who have experienced trauma without becoming aggressive may still be emotionally troubled (Luthar & Zigler, 1991).

There is immense variability of children and heterogeneous results of child maltreatment. One cultural or social factor may only briefly affect one child and devastate another. Garbarino (1995) uses the analogy of children as the barometers of our social and cultural woes. “There is a kind of psychological asthma that some children and youths have that makes them particularly vulnerable to whatever social toxins are in their environment” (Garbarino, 1998, p. 361). Some children are more sensitive to these ills and show marked responses rather quickly like the canary brought into the mine to warn miners of dangerous levels of gas. Unfortunately, the bird typically died in the process.
Given the variability of children, their experiences and the impact upon them from maltreatment, is there some indication of which children who experience maltreatment will suffer great, lifelong trauma and which will survive less scathed? One possible clue is risk factors which are oft discussed in regards to child abuse (Karoly et al., 1998).

**Risk Factors and Child Maltreatment**

Risk is the probability of a future event given certain conditions (Fraser et al., 1999). Risk factors are markers or correlates and possibly even causes of child maltreatment. Individual characteristics, specific experiences, and contextual factors can all be risk factors for child abuse and neglect (Fraser et al., 1999).

The etiology of child maltreatment is highly complex (Belsky, 1993). Child maltreatment is a function of both protective factors and risk factors. Risk factors contributing to child abuse and neglect include but are not limited to: parental substance abuse, parental mental illness, parental mental retardation, childhood disability, domestic violence, lack of parenting skills and knowledge, extreme poverty, social isolation, family history of abuse, and life stress overload (National Clearinghouse on Child Abuse and Neglect Information, 1998c).

Contributing factors vary historically, such as the societal attitudes regarding family privacy at a given time, and culturally, like the tolerance for violence in different societies. They may be contemporaneous, as in the case of poverty. Contributing factors may be situational, such as a crying episode or may be related to specific parental and child attributes (Belsky, 1993). Hence, “child physical abuse and neglect are often
coterminous, but independent, entities, with separate, though similar, etiologies and trajectories” (Lyons, 1998, p. 33). Child maltreatment is a conglomeration of many factors with paths of their own and parallel effects and interactions. Belsky (1993) concluded: “physical child abuse and neglect are multiply determined by factors operating at multiple levels of analysis (developmental, immediate-situational, demographic, cultural-historical, evolutionary). There is no one pathway to the disturbance in parenting; rather, maltreatment seems to come when stressors outweigh supports and risks are greater than protective factors” (p. 427).

Complicating the issues of risk and protection are nonspecific risk factors. These are factors that elevate risk for a variety of conditions. For example, poverty increases a child’s chance of maltreatment, lead poisoning, neighborhood violence, behavior problems and many other negative outcomes. Not only are there many nonspecific risk factors that are linked to child neglect and abuse, child abuse is a nonspecific risk factor itself. Child maltreatment, along with its related issues of chronic family conflict and unskilled parenting, are nonspecific risk factors for a variety of individual and social problems such as delinquency, violence and psychopathology (Buka & Earls, 1993; Fraser et al., 1999; van der Kolk & Fisler, 1994). Hence, risk and protective factors become a circle in which it is very difficult to discern a beginning point and which caused what.

Fraser and associates (1999) contend that there is no accepted empirical or theoretical ground on which to assess degrees of risk or resiliency. Furthermore, there is evidence that focusing on resiliency factors may not provide the answers we need. “To date, data suggests that resilience is rare among the highest risk children who are
disadvantaged by poverty, poor prenatal care, abusive or neglectful parenting, and
dangerous neighborhoods” (Fraser et al., 1999, p. 138). Just as there is no mutually
exclusive explanation in nature or nurture, there is no simplified pathway through
childhood. There are complex multiple pathways full of interactions so that there is no
single conduit to the problem or solution.

A Better Definition

When one delves more deeply into the issue of child maltreatment, the
complexities of etiology and definitions can cloud the issue. Virtually all communities
have children subjected to severe physical punishment or receiving care which is below
that community’s standards (U.S. Department of Health and Human Services, 1999).
However, child abuse and neglect laws do not specify what is or is not acceptable in
operational terms. Hence, “there is no objective point of demarcation between
punishment and abuse or between minimal acceptable care and neglect” (U.S.
Department of Health and Human Services, 1999, p. 115). What is child abuse to one
person may seem appropriate discipline to another. Legal definitions vary and
community standards differ. Even the definition of what constitutes a child is not as easy
as it may appear. The Child Abuse Prevention and Treatment Act of 1996 states a child
is a person who has not attained the age of 18 except in the case of sexual abuse where
the age may be different depending on statutes in the state in which the child resides
(U.S. Department of Health and Human Services, 1996). For example, since states are
responsible for providing their own definition, some states include mentally handicapped
persons to age 21, others to any age.
More importantly, beyond these debates and discussions are children—children who are growing up in nurturing or harmful environments. As previously stated, two-thirds of all reported child maltreatment victims are dismissed from the system as unsubstantiated allegations. It is difficult to believe that the level of false allegations is that high. Looking only at the more simply defined sexual abuse, 20-45% of female and 10-18% of male adults recall being sexually abused as children, indicating underestimation as the more reasonable concern (Belsky, 1993; Morrow & Smith, 1995; National Clearinghouse on Child Abuse and Neglect, 1996; U.S. Department of Health and Human Services, 1999). Failure to prove or substantiate a single act of injury or neglect provides no indication of the quality of life and care giving for the child. For this reason, this author suggests focusing upon the children, the poor outcomes originating in childhood, and the enormous potential of children.

If the function of the family is to nurture one another, then family violence is the antithesis of this. Family violence, of which child maltreatment is just one form, is common to all societies and ranges from spanking to homicide (Kempe, 1980; Lysted, 1974). The discussions of what constitutes a “family” and “violence” can mask the issues of children being harmed and blur the focus on the child.

By focusing only on parental acts of commission or omission, the impact of the overall quality of care the child receives over time is removed to a place of lesser importance. Yet, it is these patterns of care which have the most impact on a child’s development and attachment.

Simplistically, the role of parents is to provide their children “good (or good enough) parenting” (Hoghughi & Speight, 1998, p. 293). Comparably, the task of the
child is to mature. Children vary widely in potential and in their response to the world. One can move beyond these long and oft-argued issues if one accepts the assumption that the optimal growth and development of children is the aim.

To be clear, a focus on early childhood is not the panacea to all social ills. Nonetheless, it is the period when children are most dependent on their caretakers and when profound physiological changes which are the foundation of a child’s attitudes and habits are formed (Buka & Earls, 1993; Hoghughi & Speight, 1998). This focus on the tender years has gained attention in other arenas such as juvenile crime. “More and more evidence seems to suggest that successful efforts to curb violent behavior should begin early in a child’s life” (Buka & Earls, 1993, p. 46). Hoghughi and Speight (1998) state that “poor parenting itself is the single factor most likely to respond to a preventive strategy because it is easily identified early in a child’s life and very likely that its association with subsequent criminality is a causative one” (p. 295). The mental health field has also focused on the mental health of infants as the key to the prevention of future mental disorders through the lifespan (Fonagy, 1998).
Chapter 2: Literature Review

Prevention

From an examination of the effects of childhood maltreatment on children, this author argues that prevention offers benefits that interventions cannot. Disturbances in brain development and attachment and loss of self-regulation are very difficult to reverse. A child’s death by maltreatment is impossible to undo. Focusing on new babies is generally preventive rather than interventive due to the young age. A human baby is completely dependent on caretakers from birth so good care is important from the beginning. Schinke and Cole (1998) have asserted that prevention is supported more in theory than in practice, specifically in the fields of social work and mental health. Nonetheless, the benefits can be enormous.

The costs of maltreated children are high with investigation, intervention and treatment by local, state and federal agencies, including the expensive programs of family preservation, foster care, and residential treatment. Expenditures also are incurred by the law enforcement, judicial, health and mental health systems responding to abused and neglected children and their families (National Clearinghouse on Child Abuse and Neglect Information, 1998d).

Treatment is essential but focusing on treatment can ignore the larger picture and can give the illusion that societal problems are being solved (Wodarski, 1998). However well-intentioned, treatment does not generally reduce the incidence of new cases (Wodarski, 1998). Hence, it is not only more humane to engage in preventive efforts with young children, it is more effective, easier and cheaper in the long run.
Prevention can be highly cost-effective. Estimates for a prevention program including comprehensive parent education and home visitation for every family in Michigan expecting their first child amounted to only 5% of the total State costs for maltreatment. Prevention services were projected at $43 million while analysts figured that child maltreatment and inadequate prenatal care cost the State approximately $823 million (National Clearinghouse on Child Abuse and Neglect Information, 1998d). To offset the costs of prevention in Colorado, a program would only need to reduce current child maltreatment expenditures by 6% (1998). Unfortunately, “our society has not yet committed itself to supporting families during this critical developmental period” (Buka & Earls, 1993, p. 48).

The early years may offer the greatest opportunity to promote long-lasting positive functioning and the greatest potential to prevent the worst damage (Guterman, 1997). Prevention can be cost-effective at reducing the long-term consequences of child abuse and neglect, with large payback curves if the child reaches a productive adulthood (National Clearinghouse on Child Abuse and Neglect Information, 1998c). Besides dollar savings, a range of multiple consequences may be avoided—consequences ranging from mild to severe injury, brain damage, chronic low self-esteem, problems with bonding and forming relationships, developmental delays, learning disorders, aggressive behavior, depression, post-traumatic stress disorder, conduct disorder, low academic achievement, teen pregnancy, drug use, juvenile criminality and adult criminality (National Clearinghouse on Child Abuse and Neglect Information, 1998d). “Current findings suggest that over the long-term, prevention pays” (National Clearinghouse on Child Abuse and Neglect Information, 1998d, p. 5). Given what is now known about the
impact of child maltreatment on brain development and attachment, prevention appears not just beneficial from the perspective of costs but more compassionate as well.

**Prevention Types**

Generally, there are four models of child abuse prevention: public awareness campaigns, parent education programs, skills-based curricula for children, and home visitation programs (National Clearinghouse on Child Abuse and Neglect Information, 1998b). Child abuse and prevention activities can be targeted to three levels of clientele. The first is called primary prevention because it is directed at the general population with the goal of stopping occurrences of maltreatment (Guterman, 1997). Public service announcements are an example of primary prevention efforts. Secondary prevention activities are targeted to specific families at high risk of child maltreatment like parent education programs in high schools for teen mothers. Tertiary prevention is directed at families where child maltreatment has occurred with the aim of preventing recurrence. Family preservation and mental health services are examples of tertiary efforts (National Clearinghouse on Child Abuse and Neglect Information, 1998b).

Tertiary programs generally exist in varying degrees in all communities and few would argue their necessity. Services for families who have already abused or neglected their children have been evaluated for years with less than promising results. Wolfe (1993) surmises that the doubtful effectiveness of tertiary treatment is logical given that the parents avoided services until the problem became severe, and services were being forced upon them. Conflict and crises are inherent in a child abuse investigation and such an adversarial relationship fails to promote an optimal balance between the needs of the
child and the abilities of the parent (Wolfe, 1993). Furthermore, tertiary treatment involves the more difficult task of reversing ingrained interaction patterns.

Primary prevention offers advantages that tertiary programs cannot. Furthermore, given the complex etiology of child maltreatment, primary prevention offers the best chance of reaching those in possible need before harm occurs. It does so without the difficulties of choosing a particular risk factor and then identifying parents with those as faced by secondary prevention projects. The lines between primary and secondary may not always be clear, but in theory, primary prevention has the greatest potential to positively impact the lives of children. Home visitation is becoming the most prevalent form of primary prevention (Gomby, Culross, & Behrman, 1999).

Home Visitation as Child Maltreatment Prevention

It is easier and more cost-effective to provide developmental, enriching, and therapeutic services earlier rather than later (Miranda et al., 1998). With the costs of child abuse, neglect, and poor parenting so high, the option of prevention is more attractive. In September 1991, the U.S. Advisory Board on Child Abuse and Neglect unanimously "recommended that the federal government immediately begin phasing in a national universal home visiting program for children during the neonatal period" (Krugman, 1993, p. 184).

Home visiting programs utilize a home-based method of service delivery targeted at families with young children. The goals of such programs are primarily preventive in nature (Gomby et al., 1999). Home visitation programs may have diverse goals but all “share a focus on the importance of children’s early years and on the pivotal role parents
play in shaping children’s lives, and by the sense that one of the best ways to reach families with young children is by bringing services to them, rather than expecting them to seek assistance” (Gomby et al., 1999, p. 4). Because of the young age of the child, preventive interventions have focused on the interactions and care provided by the primary caregiver. To address these interactions in a natural setting, preventive interventions have been occurring in homes.

Since 1993, home visiting programs have blossomed (Gomby et al., 1999). However, home visitation is not a new concept. It is as old as the professions of public health nursing, philanthropy and social work which all share roots in the friendly visitors of the nineteenth century. In response to the rapid changes of industrialization, urbanization and rampant poverty in the United States, wealthier persons, mainly women, visited the poor in their homes attempting to assist them (DiNitto & McNeece, 1990). In addition to its rich history, home visitation has gained renewed popularity for decreasing poor childhood outcomes, namely as a result of child abuse and neglect. Since young children have traditionally spent the bulk of their time at home and the home environment has been considered a primary influence over the growth and development of children, a preventive intervention located in the home seems logical. Its value is further illuminated in light of the research on attachment and brain development as home visitation reaches children when they are most vulnerable.

Guterman (1997) examined a large body of prevention research (from 1979-1997) that attempted to isolate the impact of the preventive intervention in a controlled fashion through treatment and comparison or control groups. One of the conclusions from this review was that the home visitation model of service delivery provided stronger
outcomes than other preventive interventions. Further research has offered additional reasons for preferring home-based models of prevention. Home visiting offers widespread appeal and public support (Donnelly, 1992). It reaches isolated families least likely to participate in their community, and serves families who are too distrustful or too disorganized to successfully navigate their way into center-based programs. Learning takes place on the clients’ own terms and on their home turf where the home visitor sees the needs and conditions firsthand and has access to both parents and children (Donnelly, 1992).

**Effectiveness of Home Visitation in Preventing Child Maltreatment**

There is a great deal of literature regarding important elements of “successful” home visitation prevention programs. For example, Guterman (1997) identified 18 studies and found the more successful projects shared the following core principles:

1. Early identification and initiation of services during pregnancy or shortly after birth;
2. Voluntary participation;
3. Case management; and,
4. Parenting education and guidance.

In addition to the above, Donnelly’s (1992) review offers the following guidelines for optimum effectiveness:

1. Families should be screened for high risk;
2. Services should be provided intensely (at least weekly at first);
3. Services should be tailored to individual families;
4. Friendship, trust and social support should be stressed;

5. Services should maintain close ties with the health care system;

6. The home visitors need intensive on-going training and supervision.

Universal, long-term service provision has been recommended. Daro and McCurdy (1994) recommend that home visitation assist a family long-term (three to five years). “Though child development knowledge can be transferred to parents in a relatively brief period of time, changing attitudes and strengthening parenting and personal skills often require a longer commitment” (p. 408). Donnelly (1992) recommends services be offered universally so that all new parents have access to services that can address the wide range of personal and situational variables related to parenting behaviors. Universal service provision avoids stigma. Wolfe (1993) states most families require some assistance in child-rearing today, specifically during the child’s early years. Parents living without social support or a nearby, caring, extended family may have that gap filled by home visitation.

Measuring the effectiveness of preventive interventions can be difficult. “Practicing prevention requires the ability to forgo the satisfaction of doing something that has a more immediate and visible effect and to imagine the consequences of failure to prevent” (Lewis, 1996, p. 353). Few researchers have completed long-term studies. Nonetheless, there is some literature on the effectiveness of home visitation as a prevention measure.

Donnelly (1992) examined five studies of home visiting programs including Dr. David Olds’ model of nurse home visitation (henceforth referred to as the Olds Model), Healthy Families America (HFA), and Hawaii’s Healthy Start, the predecessor of HFA.
Donnelly found some significant intervention results in each. Rates of child abuse for intervention versus control groups were 4% to 19% in Olds and 2% to 11% in HFA, representing significant reductions in child maltreatment. Hawaii’s Healthy Start found the reported abuse rate was only .08% for the project for five years after birth in over 1,000 high-risk families. However, the overall rate of abuse cases is very low in Hawaii. Nonetheless, Donnelly concluded that the studies consistently suggest that the home visitation service approach has significant benefits in the prevention of child abuse and related family disorders.

Guterman’s (1997) previously mentioned examination of prevention research from 1979-1997 included only those with comparison or control groups. Of the 18 studies examined, ten measured child abuse reports directly, one of which was the Olds model. Only one other study significantly reduced child abuse directly. Still, from his assessment of all the results, including proximal and mediating measures of child maltreatment, he concluded that providing education and support to help parents learn to care for a new child appears essential in reducing maltreatment risk independent of particular models.

Problems in Measuring the Prevention of Child Abuse

A special issue of *The Future of Children* was devoted to examining several home visitation programs that had been studied through randomized trials (Gomby & Culross, 1999). The Olds Model and HFA were included as was the Hawaii Healthy Start predecessor of HFA, Parents As Teachers, and the Comprehensive Child Development Program. “Several models produced some benefits in parenting and perhaps in the
prevention of child abuse and neglect, but only on some of the measures used to assess these outcomes” (Gomby et al., 1999, p. 24). Measuring prevention and the non-occurrence of a phenomenon offers special challenges. In addition, measuring the prevention of child abuse presents particular difficulties.

The confusing results of some research on home visitation may be partially attributed to the difficulty in measuring child abuse. When using reported cases of child maltreatment, underreporting to child protective services is problematic. The low base rates of protective service reports even for high-risk populations cause great sensitivity even if only a very few cases are reported (Gomby et al., 1999; Guterman, 1997). Furthermore, all home visitation programs provide at least one new person in the home to observe and report any suspicions and could potentially actually increase reporting to protective services for client families. Most programs link families with other community services, providing additional monitoring by outside parties.

The fact that reports are made to child protective services by someone does not necessarily mean that the child suffered abuse or neglect. Some studies are able to isolate the substantiated cases of abuse and neglect from mere allegations, but even this distinction is problematic due to varying state definitions of “substantiated” and changes in child protective services data collection methods (Finkelhor & Jones, 2004). Further complicating this, protective results in studies varied over time. The Olds study followed participants for 15 years and found that early significant results appeared to later wash out in school age years. Nevertheless, over the course of the 15 years, overall significant and impressive reductions in child abuse and neglect reports were found (Guterman, 1997; Olds et al., 1997). Few programs have the ability to conduct such longitudinal
studies and so may be victims of the fluctuations within the time period in which they
gather their data. “Knowledge development has been significantly hampered by
methodological limitations present in many of the existing studies. These limitations
include small sample sizes, the use of problematic outcome indicators, and brief follow-
up periods” (Guterman, 1997, p. 22). Even Dr. Olds, whose previous research results
were so strong in this area, was not able to use child maltreatment outcomes from child
protective service reports in his most recent study due to the low base rate of verified
cases of child maltreatment (Olds et al., 2002). Instead, like most programs to date,
effectiveness studies use moderators or measures of family characteristics that
“moderate” child maltreatment such as parent-child interaction and the home
environment (Gomby, Larner, Stevenson, Lewitt, & Behrman, 1995).

Despite research design problems, Guterman (1997) stated, “the wide array of
studies noting some positive outcomes in families receiving treatment suggests that early
intervention does indeed hold the power to avert physical child abuse and neglect” (p.
22). Daro and McCurdy (1994) state, “although the present pool of evaluative research
most certainly has its limitations, it does offer preliminary guidelines for shaping
programs and systems and for articulating the critical issues calling for further study” (p.
405). If this is the case, then why have several of the programs shown less than crystal
clear results in preventing child abuse and neglect? Complications arising from the
definitions and measurement of abuse and neglect offer one answer, and the varying
etiology of child abuse and neglect offers another.

Child abuse is a multifaceted problem. Each aspect of child abuse and neglect has
somewhat different underlying causes. Sexual, physical, and emotional abuse can occur
simultaneously and are not orthogonal (Donnelly, 1992). “To be successful, child abuse and neglect prevention efforts must ultimately take into account the various causes--both personal and societal--that play a role in the evolution of the problem” (Donnelly, 1992, p. 25). Complex prevention efforts can seek to modify problems at the micro-level (parent and child), meso-level (neighborhood) and/or macro-level (broader social forces in culture, history, economics and politics) (Guterman, 1997). Few efforts can address all three levels and “no amount of home visits will take the place of jobs that provide decent incomes, affordable housing, appropriate health care, optimal family configurations or integrated neighborhoods where children encounter positive role models” (Donnelly, 1992, p. 28).

Nonetheless, as previously stated, concentrating only on abusive or neglectful acts by parents against their child obscures the larger issue of the overall quality of care the child receives over time. Daily interaction and patterns of care by parents have the largest impact on a child’s brain development and attachment. The many measures of parent-child interaction and home environment used in home visitation programs have measured positive changes in the growth and development of children in these areas. Many positive cognitive, social, and health outcomes for children served by home visiting programs have been established resulting in the espousal of the overall model of home visitation (Gomby et al., 1995).

It is possible that the many disagreements and the confusion surrounding the measurement of the effectiveness of home visitation have their roots in the very ways people look at measurement. For the purposes of an analysis of home visitation prevention programs from a paradigmatic perspective, the two largest home visitation
programs will be compared: The Nurse Family Partnership by Dr. David Olds and Healthy Families America.

Models of Home Visitation

The U.S. Advisory Board on Child Abuse and Neglect presented two home visitation prevention programs with evidence-based research to support the value of home visitation (Krugman, 1993). These were the model developed by Dr. David Olds and the Hawaii Healthy Start Program, predecessor of Healthy Families America (Krugman, 1993). However, there are various models of home visitation prevention programs and the many models and community specific adaptations offer infinite possibilities and combinations. Nonetheless, the available research and information can be simplistically and broadly divided into two categories: the clearly contained and well-defined model of nurse home visitation developed by Dr. David Olds, and those which can broadly be categorized as congruent with the Healthy Families America model of home visitation. Table 1 presents a comparison of the key features of these two home visitation models.
Table 1
Comparison of the Key Features of the Home Visitation Models of Dr. David Olds and Healthy Families America

<table>
<thead>
<tr>
<th></th>
<th>Dr. David Olds Nurse Home Visitation</th>
<th>Healthy Families America Home Visitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff</strong></td>
<td>Nurses</td>
<td>Professionals from any field as well as paraprofessionals</td>
</tr>
<tr>
<td><strong>Staff Training</strong></td>
<td>15 days spread over the first year conducted in Denver or by Denver staff regionally, and Nursing Child Assessment Satellite Training (NCAST)</td>
<td>HFA Primary (Core) Training (4 days offered throughout the country)</td>
</tr>
<tr>
<td><strong>Staff Supervision</strong></td>
<td>Minimum ½ time supervisor for every 4 nurses</td>
<td>Weekly supervision</td>
</tr>
<tr>
<td><strong>Caseload</strong></td>
<td>25</td>
<td>10-15</td>
</tr>
<tr>
<td><strong>Program Entry</strong></td>
<td>Prenatally, prior to 5 months gestation</td>
<td>Prenatally or later</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>Child reaches two years of age</td>
<td>Child reaches three to five years of age</td>
</tr>
<tr>
<td><strong>Target Population</strong></td>
<td>Targeted (low-income, at-risk, first time mothers)</td>
<td>Universal screening, targeted intervention</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Dr. David Olds Nurse</th>
<th>Healthy Families America</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Visitation</td>
<td>Home Visitation</td>
<td></td>
</tr>
<tr>
<td>Curriculum</td>
<td>Partners in Parenting</td>
<td>Multiple curriculum used and chosen</td>
</tr>
<tr>
<td></td>
<td>Education (PIPE) curriculum included in training.</td>
<td>by the programs such as: Partners in Parenting Education (PIPE), Parents as Teachers (PAT), Meld, HFA Great Beginnings, Partners for a Healthy Baby</td>
</tr>
<tr>
<td>Intervention</td>
<td>Visits must follow protocols available only from Olds for his replication sites</td>
<td>Community unique models designed by program implementers based on general principles (HFA critical elements)</td>
</tr>
<tr>
<td>Replication</td>
<td>Controlled replication in sites chosen by Olds only</td>
<td>Replication materials available from Healthy Families America free of charge.</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Designed and managed by Olds</td>
<td>Locally designed</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Dr. David Olds Nurse Home Visitation</th>
<th>Healthy Families America Home Visitation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcomes</strong></td>
<td><strong>Outcomes</strong></td>
</tr>
<tr>
<td>• 79% fewer verified reports of child abuse and neglect</td>
<td>• 3.3% substantiated abuse and neglect cases as compared to 6.8% in control (p&lt; .01).</td>
</tr>
<tr>
<td>• 30 months less receipt of Aid to Families with Dependent Children</td>
<td>• Significant improvements in maternal involvement, maternal sensitivity to child cues, and parenting knowledge (p&lt; .08) (from Hawaii (Daro &amp; Harding, 1999))</td>
</tr>
<tr>
<td>• 69% fewer maternal arrests</td>
<td></td>
</tr>
<tr>
<td>• 60% fewer instances of running away by the children through age 15 years (Elliot, 1998)</td>
<td></td>
</tr>
</tbody>
</table>
Dr. David Olds’ Nurse Home Visitation Model.

Olds began his first trial in Elmira, New York in 1977 with “a program model designed to address the major modifiable risks for poor outcomes of pregnancy, dysfunctional care giving, and compromised maternal life course” (Olds & Korfmacher, 1997a, p. 2). Many articles have been published on the results of these and subsequent trials since the mid-1980s (Olds et al., 1997; Olds, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, Henderson, Cole et al., 1998; Olds, Henderson, & Kitzman, 1994; Olds, Henderson, Tatelbaum, & Chamberlin, 1986, 1998). None of these articles include specific information regarding the particular activities of the program and Olds himself appears to control information dissemination and replication projects in great detail. Evaluation of an Olds replication program is designed and managed by Olds himself. The most detailed information available defines the following core elements:

1. The program is focused on low-income, first-time mothers.
2. Only nurses are to be employed as home visitors.
3. Nurse home visits begin during early pregnancy and continue for two years after the child is born.
4. Nurse home visitors follow a visitation schedule that varies over the two and one half years a family is in the program (weekly visits during the first month of enrollment; visits every other week for the remainder of the pregnancy; weekly visits during the first six weeks after delivery; visits every other week thereafter until the 21st month of childhood; monthly visits until the child reaches age two).
5. Nurse home visitors follow a comprehensive program protocol that focuses on mother's personal health, environmental health, quality of care giving for the infant and toddler, and mother's personal development (such as preventing unintended pregnancies and finding work).

6. Nurse home visitors are expected to involve family members and friends in the program and to help families use other community health and human services they may need.

7. A full-time nurse home visitor carries a caseload of no more than 25 families.

8. A team of nurse home visitors should have a well-prepared nursing supervisor to provide guidance and oversee program implementation.

9. Detailed records are kept on families and their needs, services provided, and progress and outcomes realized (Elliot, 1998, p. 31).

**Healthy Families America Home Visitation Model.**

Healthy Families America (HFA) grew from the Hawaii Healthy Start program and “is an initiative that promotes positive parenting and child health and development, thereby preventing child abuse and other poor childhood outcomes” (National Committee to Prevent Child Abuse, 1995a, p. 1). Since the goal of Healthy Families America is to establish a universal home visitation system for all new parents, much free information is available along with directions for replication (National Committee to Prevent Child Abuse, 1995a, 1995b, 1997). The Healthy Families America approach to home visitation is defined by a set of critical program elements:

1. Initiate services prenatally or at birth.
2. Use a standardized (i.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services.

3. Offer services voluntarily.

4. Offer services intensively (at least once a week) with well-defined criteria for increasing or decreasing intensity of service, and over the long term (i.e., three to five years).

5. Services should be culturally competent such that the staff acknowledges and respects cultural differences among participants; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.

6. Services should focus on supporting the parent as well as supporting the parent-child interaction and child development.

7. At a minimum, all families should be linked to a primary healthcare medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.).

8. Services should be provided by staff with limited caseloads (10 to 15).

9. Service providers should be selected because of their personal characteristics (i.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.).

10. Service providers should have a framework for handling the variety of experiences they may encounter when working with at-risk families. Basic and intensive training is essential.
11. Service providers should receive ongoing effective supervision (National Committee to Prevent Child Abuse, 1995b).

The HFA model has less clear boundaries than that of Olds, as may be inherent in a community driven and designed model. Vastly different programs can apply for Healthy Families America credentials as long as they address the core elements of home visiting espoused by HFA. Other programs such as the Healthy Start Initiative may not be affiliated with Healthy Families America but are representative of what could be classified as an approach to home visiting congruent with HFA. Key characteristics for evaluating Healthy Families America efforts are provided and include:

1. The evaluation needs to provide for a formal control or comparison group.
2. The evaluation should include a range of outcome measures.
3. If possible, multiple methods of data collection should be used to obtain information on all critical outcome measures.
4. Ideally, the evaluation data collection system should be fully integrated into a program’s ongoing client information system.
5. Following an initial assessment of client functioning, subsequent assessments should be conducted on clients both in treatment and comparison groups at three months for the first year and six months thereafter.
6. If possible, post-program interviews or observations should be obtained on at least a sample of program recipients.
7. Efforts should be made to have at least one post-program contact with all families who drop out of services.
8. Evaluations should document the process undertaken to establish home visiting services (National Committee to Prevent Child Abuse, 1997).

These two programs are often lumped together as slightly different flavors of the same product. Healthy Families America cites the published research of Dr. Olds in its materials as support for their model (National Committee to Prevent Child Abuse, 1997). However, this approach is not welcomed by Olds himself. He expressed his frustration in a 1997 edition of the *Journal of Community Psychology* which was devoted, in its entirety, to his program (Olds & Korfmacher, 1997b). He took issue with those efforts such as the U.S. Advisory Board on Child Abuse and Neglect using his research to recommend home visitation programs without adhering to all the elements from his randomized trials (Olds & Korfmacher, 1997a).

These two similar programs have taken very divergent courses in dissemination of information and model replication. The proposed models differ not only in cost, staff and approach, but also in the very way they regard the issue of effectiveness. The frameworks from which they view knowledge and what constitutes proper ways of knowing are not the same. The divergent evolutions of these programs can be examined as a function of differing paradigms. The differing views and positions can be viewed from the underlying suppositions of positivism in the model of nurse home visitation by Olds and post-positivism in the Healthy Families America model. The belief systems that underpin each of these models are fundamentally different. These paradigmatic differences govern program implementation decisions.
Paradigms and Application to Home Visitation

For the purpose of this discussion, paradigm will be used in a broad sense indicating “a basic set of beliefs that guide action” (Guba, 1990, p. 17). The subtleties and feuds that emerge from differing paradigms often go unnoticed as a function of such. Nonetheless, these underlying belief systems have powerful effects on how one views the importance and relevance of knowledge. The major divergences in the two programs can be addressed as a function of their paradigmatic reference point.

Since paradigms are purely human constructions, “they cannot be proven or disproven” (Guba, 1990, p. 18). Rather, they flavor research, practice and other professional activities, often in confusing and unobserved ways. As tension and differences emerge between the two primary home visitation prevention models, few appear cognizant of the underlying paradigmatic differences fueling their deviation. Basic belief systems are so implicit that most people are not even aware of their own or how they came to adopt them.

The differing views and positions of these two programs can be framed within the underlying suppositions of the positivist and post-positivist paradigms. Since the fifteenth century, positivism and the subsequent paradigmatic contenders have been characterized by the ways they address ontology, epistemology and methodology (see Table 2).
Table 2
Comparison of Positivism and Post-Positivism

<table>
<thead>
<tr>
<th></th>
<th>Positivism</th>
<th>Post-positivism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontology</td>
<td>Realist</td>
<td>Critical realist</td>
</tr>
<tr>
<td>Epistemology</td>
<td>Dualist/ objectivist</td>
<td>Modified objectivist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subjectivity acknowledged</td>
</tr>
<tr>
<td>Methodology</td>
<td>Experimental empiricism</td>
<td>Critical multiplism</td>
</tr>
<tr>
<td>Role of values in research</td>
<td>None</td>
<td>Some</td>
</tr>
</tbody>
</table>

Ontology

Ontological questions attempt to answer, “What is the nature of reality?” (Guba, 1990, p. 18). Positivism is strongly grounded in realist ontology-- the existence of a reality driven by natural laws. The ultimate aim of science is to predict and control natural phenomena through experimentation (Guba, 1990). Post-positivism is a modified version of the original positivism with a critical realist ontology--the impossibility to truly know reality given our human imperfections (Guba, 1990). Guba (1990) contends “the basic belief system of post-positivism differs very little from that of positivism” (p. 23). However, within the context of application these small differences can produce very large effects. Intimately tied to the ontology, or the nature of reality, are the epistemology and methodology of a paradigm.
Epistemology

Epistemology “is the relationship between the knower (the inquirer) and the known (or knowable)” (Guba, 1990, p. 18). Positivism has a dualist/objectivist epistemology. “It is both possible and essential for the inquirer to adopt a distant, noninteractive posture. Values and other biasing and confounding factors are thereby automatically excluded from influencing the outcomes” (Guba, 1990, p. 20). Post-positivism takes a modified objectivity, purporting that biases do exist and should be acknowledged while attempts are made to control for them.

Dualism and objectivity characterize positivist epistemology where the researcher and the studied are distinctly separate entities so that the question of the impact of the practice of research itself is obscured in positivism. For positivism, objective epistemology is not only possible, but also necessary. Perhaps this can be best illustrated by the voice used by the researcher. Olds portrays the detached scientist and informer of policy makers: “Since the findings from Elmira were so promising, both in terms of program impact on maternal and child health, and in reducing government expenditures, many individuals urged us to disseminate the program to other communities in the mid-1980s. We decided instead that we first needed to learn whether the program would produce corresponding effects when it was delivered to minority families who lived in a major urban area” (Olds & Korfmacher, 1997a, p. 2). This is quite different from the voice used in some Healthy Start literature: “we need to learn to work together, since it is our babies who are dying! We are one entity, one family” (McCann, Young, & Hutten, 1995, p. 75).
Post-positivistic modified objectivity recognizes subjectivity and the role it may play in inquiry. Healthy Start asks evaluators to look at the impression of research itself on those being served, those not served, or even the community in which the research occurs.

“Healthy Start programs are geared toward empowering disenfranchised, underserved communities, but we're really doing a lot of invasive kinds of things in trying to document how effective our interventions are” (McCoy-Thompson, Vanneman, & Bloom, 1994, p. 13). HFA suggests that evaluation measures be integrated into the data collection system rather than using intrusive formalized measures.

The research process is fraught with dilemmas in trying to maximize generalizability, precision and control in measurement and realism for the participants. “The very choices and operations by which one can seek to maximize any one of these will reduce the other two” (McGrath, 1982, p. 74). According to McGrath, a good researcher knows that flawless research does not exist and directly addresses the decisions he or she makes to maximize (and in turn minimize) the various aspects throughout the inquiry process. Since a single experiment cannot maximize all three aspects, one method alone proves very little (McGrath, 1982). Hence, “multiple approaches are required” (McGrath, 1982, p. 101). Multiple methods replicate and converge but also compensate for the inherent limitations of any one method, strategy or design. Since from this perspective, research is a never-ending series of decisions to maximize one aspect at a time at the expense of the other two, it follows that a single design or approach provides a limited view of the situation.

Subjectivity is further revealed in the approach to knowledge accumulation. Positivism stresses incremental accretion of knowledge. Research should be replicated
and build upon the previous work of others. Olds appears conservative with regard to knowledge dissemination. After the initial trial in Elmira, New York, Olds replicated in Memphis, Tennessee (Olds & Korfmacher, 1997a). Following a successful replication in Memphis was a third replication in Denver, Colorado (Olds et al., 2002). Yet for Olds, this is not yet enough accumulated knowledge to justify vast dissemination. Through the U.S. Department of Justice and U.S. Department of Health and Human Services funding, Olds is evaluating the dissemination process (Olds & Korfmacher, 1997a). In contrast, HFA recommends a universal system for all parents based on the positive results thus far. HFA conveys a sense of “get out there and do something” rather than fidelity to an ideal model.

**Methodology**

Methodology represents how one should go about “finding out knowledge” (Guba, 1990, p. 18). Methodologically, positivism is rooted in manipulative experimentation with the ultimate manipulation being random assignment. “Questions and/or hypotheses are stated in advance in propositional form and subjected to empirical tests (falsification) under carefully controlled conditions” (Guba, 1990, p. 20). From a post-positivist perspective, experimental methodology is modified with emphasis on critical multiplism. “If human sensory and intellective mechanisms cannot be relied upon, it is essential that the ‘findings’ of an inquiry be based on as many sources-- of data, investigators, theories, and methods-- as possible” (Guba, 1990, p. 21).

The question of a program's effectiveness is closely tied to the underlying assumptions about how one goes about answering such a question. Hence, the
methodology used by models of home visitation provides an indication of the paradigm in use. The preference for random assignment is clearly articulated by Olds. The titles of several of his journal articles include the phrase “a randomized trial of nurse home visitation” (Olds et al., 1994; Olds, Henderson, Tatelbaum et al., 1986, 1998). From a positivist perspective, Olds looked at other randomized trials of prenatal and infancy home visitation services and concluded not all had positive effects (Olds & Korfmacher, 1997a). The strong bias towards the value of research, based on randomization, can be seen by his dismissal of programs evaluated using other methods and refusal to even discuss their implications. Combes-Orme, Reis and Ward (1985) discuss cuts in the funding of home visitation programs in the 70s and 80s. Olds attributes funding decreases to a lack of randomized trials and explains “studies prior to the early 1980s usually employed research designs that failed to rule out the major threats to the validity of inferences regarding program effectiveness. Rarely were such programs studied in the context of randomized trials” (Olds & Korfmacher, 1997a, p. 2).

Healthy Families America takes a different approach. From a post-positivist perspective, critical multiplism is appropriate experimental methodology. HFA admits “in order to attribute client improvements to the provision of home visitor services, you need to be able to report on the experiences of a similar group of parents who did not receive the intervention. This is best done by randomly assigning clients” (National Committee to Prevent Child Abuse, 1995a, p. 1). Standardized methods provide one mode of data collection but multiple methods should be used (National Committee to Prevent Child Abuse, 1995a). The implication is that since randomized trials have already been completed and have established the usefulness of home visitation, other
models of research should now be employed. Model application and effectiveness need to be established in a multitude of ways. Hence, a wide variety of inquiries are appropriate and valuable with methods encouraged that would best fit the site of a particular program.

Other programs have also expressed this belief in other ways. “The results I'm talking about are holistic results, not just looking at the numbers based on the medical model” (McCann et al., 1995, p. 35); and, “we are willing to settle for less information in order to get valuable information” (McCann et al., 1995, p. 36); or, “numbers don't tell you enough” (McCann et al., 1995, p. 40). In post-positivism there is a balance of research among randomized trials and other methods of inquiry. Qualitative and ethnographic studies are encouraged. For example, “a centerpiece of the New York site's evaluation effort is the ethnographic analysis of New York's Healthy Start's three diverse and distinct communities” (McCann et al., 1995, p. 39). Programs are encouraged to rely not just on quantitative information but to have qualitative pursuits as well (McCann et al., 1995).

For post-positivism, random assignment may still be held in esteem, but disadvantages can also be acknowledged. Random assignment with a control group can pose an ethical problem for those not receiving any help. The deliberate lack of services to those in the control group occurs at a critical time - a time that can never be replicated in the brain of the young child. This is not a simple question of evaluation methods; for some communities and persons there is an emotional pull towards those not served. “Consider the ramifications of providing intensive services to a few people, compared to providing less intensive services to a larger group. Community agencies that serve
clients comprehensively may be forced to turn away clients because scarce resources prevent universal coverage. These clients may be served elsewhere, but not as intensively, or they may not be served at all” (McCoy-Thompson et al., 1994, p. 3).

Disadvantages of randomization are not addressed by Olds directly since the underlying assumption--randomization precludes major threats to the validity of inferences is the ultimate proof in scientific terms--is unstated. However, one could argue on his behalf that it is not yet known if the control group is at a disadvantage. This cannot be addressed until the treatment has been proven effective. What if the treatment were discovered actually to be detrimental? Certainly, in that case there would no longer be an ethical issue of those in the control group not receiving services. It may also be noted that Western society is focused on action and we may be more comfortable with doing anything rather than the slower process of teasing out only the effective pieces of our actions.

**Purpose**

An important issue that crosses methodological, epistemological and ontological issues is purpose. The purpose of research is rarely directly addressed but is inherent in any discussion of inquiry. Positivism has an underlying supposition that we live in an empirical world where rational decision-making rules and objectively conducted research with positive findings is then put into practice. Others have disagreed. “The formation of social policy is completely and irrevocably driven by human value positions- not science” (Hudson, 1994, p. 173). Post-positivism allows room for the roles that politics and community values play in which programs are implemented or forgotten. Research
can be used to support the argument for implementation of a particular program but does not necessarily need a randomized design. Furthermore, numbers can be deceiving. No amount of research is likely to convince a politician or anyone else with different values to change his or her position. One can always find some flaw in the data, analysis or interpretation because “there is no perfect study” (Einbinder & Kirk, 1994, p. 196). Because it is impossible to maximize simultaneously the accuracy, utility, feasibility and propriety of an inquiry, one can always find fault in at least one of these areas. In this way, the argument over the type of research being conducted can be used to mask an underlying value debate.

Post-positivism is accommodating to the values and views of others. HFA stresses the importance of community values when developing a program. Since an HFA model can identify its own community needs, community members are involved in planning, implementation, and even as employees of the program. This is because community empowerment is important and necessary within the home visitation services of an HFA program. Olds has a “nurses-only policy” and has repeatedly reported that only bachelors-level nurses should be used as they have the only proven success in client outcomes in his randomized trials (Olds et al., 2002). Conversely, Healthy Families America recommends staffing with those professionals or paraprofessionals who are culturally competent for the local population to be served regardless of their occupation. HFA recognizes that the very existence of, or continued funding for, a prevention program may depend on community support. Healthy Start and Healthy Families America offer entire volumes on consortia development (McCoy-Thompson, 1994; National Committee to Prevent Child Abuse, 1997). “You've got to reach down to the
grassroots. Sustainability has to do with a buy-in at the local level. And if the people you work with don't buy in, that project will not succeed. I didn't say 'may not succeed' - I said 'will not succeed'” (McCann et al., 1995, p. 61). Each community must forge its own pathway from ideal to unique, as no single program is likely to meet the needs of all families over time.

Post-positivism declares there is an imbalance in positivism of internal validity at the expense of external validity. Internal validity represents the confidence one has that the intervention was the actual cause of the result (Rubin & Babbie, 1997). External validity is the degree to which a study's findings “can be generalized to other populations and settings” (Stern & Kalof, 1996, p. 63). The two program types seem juxtaposed on this issue with Olds adhering to internal validity by randomization and model fidelity and HFA concerned with a universal system of home visitation. Such vast dissemination is only possible through flexible replication strategies. The HFA model suggests that everyone needs some help and support when becoming a new parent and caring for a completely helpless and sometimes frustrating newborn. Many people have family and friends to offer appropriate support, but others do not. For those without adequate help, a home visitor can fill the void, normalizing the prevention process. If nurturing new families is widely valued and available to all, the program is non-stigmatizing. This has been the case in Europe where universal home visiting has been in place for decades (Kamerman & Kahn, 1993).

Being sensitive to the political climate, a program serving only poor women and their children may not be the best political strategy. Children and their mothers are undervalued in our society (Schaef, 1992). This depreciation is more pronounced in poor
women. By focusing on the commonalities of all families and mothers, HFA avoids the risk that the research can just as easily be crafted to continue support for the devaluing of women and children.

In contrast to HFA’s universality, the Olds model targets low socioeconomic status (SES), expectant women. In 1997, Olds and associates reported that the money spent on home visiting with low SES women is regained in savings within four years, largely through welfare dollars. This is not possible with higher SES women who do not access welfare dollars since the figures did not address many of the direct and indirect costs of child abuse prevention or the non-monetary gains that may be experienced by higher SES families.

A post-positivist criticism of positivism is that it fails to recognize bias in research. According to Thomas Kuhn, when a man is striving to solve a problem, he knows what he wants to achieve and designs his instruments and directs his thoughts accordingly (Pajares, 1998). If Olds started his research to see if his ideas would save public monies by lowering welfare expenses and preventing subsequent pregnancies, then data on welfare use and subsequent pregnancies would be collected. It could be argued that the mere collection of welfare use and subsequent pregnancy data confirms this bias. This issue of the purpose of research is a bit troubling here and may answer the question as to why Olds stresses a targeted approach. Would the American public be interested in a program that reduces future pregnancy rates in all women? It is unlikely to be well received if the goal is to reduce the number of births to affluent families as well. Criticism of having too many children is only acceptable when directed towards our poor.
If the purpose of the research is to predict and control, generalizing the program to everyone could have some insidious effects.

The information from both Olds and other models of home visitation seems to point rather definitively towards the preventive value of home visiting. Whether one measures dollars or positive personal change, no negative impacts have apparently been found. Excluding funding and political priorities, the decision in a community of whether any home visitation program is useful is probably a clear one. However, should a community decide to implement a program, a choice of approach must be made. The author has proposed that the major divergences in the two program types can be addressed as a function of their paradigmatic reference points and are a function of the underlying suppositions of positivism in Olds' and post-positivism in the Healthy Families America models. Hence, implementation choices may actually depend on the paradigm or paradigms of those involved in making the decision. If the leaders or decision makers in a given community come from a positivist perspective, they are likely to prefer the Olds model with its high internal validity and randomized trials. Those of a post-positivist or subsequent paradigmatic view may feel more comfortable with Healthy Families America’s value driven and community focus. Both decisions are logical and valid.

The two models of home visitation presented have similarities and differences. These differences can be viewed as representative of differing paradigms. Since paradigms can be neither proven nor disproven, and a single study design is of little merit, the question of which is the better model cannot be answered. Rather, might it be more useful and a better use of resources to examine aspects of both home visitation
models that contribute to their effectiveness? For example, since both models use home
visitors, what sorts of qualities enable them to do this work?

Regardless of model, in working towards a better future for the children of today
and tomorrow, it is important for research, theory and practice to work collectively. For
the important issue of our nation's children, all three must be integrated together. When
looking at the relative importance of research, theory and practice, benefits are visible for
both Olds and HFA. Perhaps by recognizing the underlying paradigmatic differences as
the source of disagreement, we will be able to communicate more productively and work
more collectively. In order to do so, theory and its role in child abuse prevention through
home visitation should be explored.

A theory is a group of propositions used to explain phenomena (Stein & Su,
1980). Theories are sets of propositions, meaning that they are not yet proven to be true
(and may never be). Theories offer models with concepts, facts, hypotheses, and
emphasizes that theories must explain interactions between people with specific
characteristics.

Does one need a theory for practice or research with children and their families?
Whether stated or not, theories play a role in practice. Turner (1996) reminds us that
theories come from individuals and hence are individual constructs. Home visitors and
researchers are individuals and their “theory and practice are inexorably interconnected”
(Turner, 1996, p. 1). Hence, defined theory could be very relevant to interventions and
research of child maltreatment prevention through home visitation.
Theories are concerned with human behavior and trying to discern why people do what they do. Although very numerous, theories of human behavior can be divided into two broad types: (a) theories of biological determinism such as Freud's and Erikson's, and, (b) theories that focus on the sociological influences on development such as those of the neo-Freudian's, for example, sociological, systems, and feminist theories (Rawlings & Carter, 1977). A criticism of deterministic theories is that many have been personality theories of and by men (Rawlings & Carter, 1977). Even though Freud studied women, invented psychotherapy, and has had an enormous influence on Western culture, “the gravest distortion in Freud's theory of female psychology stems from his failure to separate two radically different phenomena, feminine biology and feminine status” (Rawlings & Carter, 1977, p. 14).

The impact of prevention programs for young children is intimately tied to the home visitor’s interactions with the child’s primary caregiver. It is consistent across home visitation programs to support the child’s caretakers so they may better nurture their children. Primary caretakers of young children are predominantly their mothers. This is not to dispute the roles that others can and do play in the growth and development of children, but to state the simple fact that most efforts to address the development of infants and toddlers do so through interactions with their mothers.

All mothers are by definition, women. Therefore, a program intending to impact the mother's relationship with the child must attend to the mother as well as the child. Although there is a great deal of research on mothers' interactions with their children and how parent/child interaction affects child development, there is far less information on the development of mothers (Mc Bride, 1973). The purpose of this discussion is not to
argue the role of mothers or the complex differences between mothering and fathering. Rather, it explores the role of home visitation programs and prevention research in support of mothers.

Since home visitors are working with mothers, the second group of theories seems more applicable here considering the role of women in home visitation. Although congruent with the doctrine of individual responsibility prevalent in Western society, its lack of attention to social factors and location of the problem within the client renders biological deterministic theories less congruent with social work values (Valentich, 1996). Instead, feminist theories address the socially caused and correctable roots of women's inferior status and their economic dependence on men.

The lives of mothers as women affect their caretaking. The quality of mothering, in turn, affects the growth and development of children. Feminist theory is supportive of helping mothers and children. Hence, feminist theory should be helpful for working with mothers as well as investigating the outcomes of such efforts.

Feminism Theory in Home Visitation

Feminist theories are value driven and home visitation is congruent with feminist principles. In order to discuss a feminist framework, a common understanding of what is meant here by feminism is needed. There are a plethora of meanings attached to the term “feminism.” There is liberal feminism, radical feminism, socialist feminism, ecological feminism, Marxist feminism, and lesbian and gay feminism, just to name a few. The following common definition of feminism can be found in the dictionary: “(a) the principle that women should have political, economic, and social rights for women equal
to those of men (and) (b) the movement to win such rights for women” (Agnes, 2004, p. 522). However, this is not especially useful in working with mothers as this is a role that is unique to women. In addition, the above definition seems to represent the negative connotation of those elements in feminism from which people (including feminists) wish to distance themselves (Harding, 1991). Part of the difficulty in defining feminism is that it is not monolithic (Harding, 1991). Feminists themselves do not agree even with one another (Nes & Iadicola, 1989). Although not easily defined, a basic understanding of what is meant by feminism in this discussion is essential.

Van Den Burgh (1995) offers the following definition for use: “a conceptual framework and mode of analysis that has analyzed the status of women cross-culturally and historically to explain dynamics and conditions undergirding disparities in sociocultural status and power between majority and minority populations” (p. xii). This definition is representative of the feminist theory presented here.

From feminist theory, the following concepts are important in an approach to working within and researching home visitation: (1) an awareness and acceptance of various standpoints, importantly feminist standpoint, (2) belief in the value of all people, (3) empowerment through collaboration and consensus, and (4) research within context.

**Feminist Standpoint Perspective**

Feminist practice with mothers is congruent with a feminist standpoint perspective. A standpoint is one’s position in society. From that standpoint certain features appear more prominent while others are obscured (Swigonski, 1994). A perspective is a broad view or a way to think about and picture situations (Minahan,
Hence, from a feminist standpoint, marginalized groups must know both the dominant worldview and their own. The concept of a feminist standpoint is rooted in Marxist theory which states that it is in the dominant group’s interest to maintain, reinforce and legitimate their own authority and understanding of the world, regardless of how incomplete it may be (Swigonski, 1994). In contrast, the perspective from subordinate groups has the potential to be more complete (Swigonski, 1994). In working with mothers and children who are subordinate members in society and the target of home visitation interventions, a feminist standpoint perspective becomes especially relevant. This perspective is relevant not just to the mothers and children, but to the home visitors as well.

A feminist standpoint perspective will flavor the home visitor’s interactions and approaches with women clients in enriching and productive ways. It is worth noting that while rarely mentioned in the literature, virtually all home visitors are women (Schafer, 1992; Wasik, 1993). This may be a reflection of the primary professions from which home visitors emerge, namely nursing and social work, but does not explain the phenomenon in its entirety or why it is rarely discussed. Is home visiting women’s work? Schaefer (1992) calls home visiting the “professionalization of early motherhood” (p. 67) implying home visitors themselves are mothers. This description may induce ambivalent feelings for home visitors, especially those that are not mothers. He goes on to state that by working with mothers and children, home visitors cannot help but become preoccupied with their “own personal existence as a woman” (p. 68).

Are female home visitors working from a feminist theory? Just because they are women does not mean that home visitors are feminist or even agree with feminist theory.
From a feminist standpoint, this becomes a relevant question. A feminist perspective helps explain the research questions that are asked by the dominant versus subordinate groups.

*The Value of all People*

It is critical that those working with a disadvantaged group believe in the value of all people. In working with women and their children, especially those living in poverty, this is particularly important. The value that all children have the right to grow free from neglect and abuse is still a relatively new one even in Western culture (Radbill, 1980). It is meaningful to note that holding all people, especially women, in esteem, does not remove any of the value of others (such as men). Our propensity to think in dichotomies is tempting but not helpful here. In fact, Harding (1991) states that promoting opposition between groups is counterproductive to the success of the feminist and society.

The optimal growth and development of all children is a value-laden statement. Yet such a statement has been implied and supported in the previous discussion of early childhood brain development. It is also obscured but pertinent in the examination of the purpose of research in home visitation. Women and children are valuable. Nurturing mothers in their role and eliminating barriers to the growth potential of their children is congruent with the home visitation model of service delivery.

*Empowerment and Practice*

When supporting women, empowerment is an oft-mentioned concept or goal. Empowerment within feminist practice recognizes that people “realize their humanity
through effective social functioning” (Swigonski, 1994, p. 389). Empowerment is therapeutic. In this case, therapy refers to the positive growth and development of full human functioning. Working with families in a home visitation model addresses positive growth and development of the children and their caretakers, typically mothers. A popular definition of therapy often includes symptom removal but that is not adequate for working with women. The pervasiveness of the pathological model focusing on mental illnesses and finding the source of dysfunction within the individual, personalizes social problems. Therefore, the anger and unhappiness many women experience is framed as illness without regard for the environmental context. Feelings by mothers of anger, depression, and guilt may be the “the non-specific responses to the role of being a woman” (Mc Bride, 1973, p. 41).

For example, a single, poor mother of three small children may fit the criteria for clinical depression. But, what if the woman lives in a violent neighborhood where she fears for her and her child's safety at all hours and so remains inside her sparsely furnished apartment with closed blinds and nothing to do? Medical treatment for her depression is unlikely to impact transformation without a change in the environmental context of her behavior. Rather than personalize the social problems, feminist practitioners often attempt to politicize personal problems (Rawlings & Carter, 1977).

Empowerment promotes self-esteem. Self-esteem is important in parenting. A parent needs to feel competent to face the unavoidable challenges of raising children. There are times, especially prior to a significant developmental milestone (i.e., walking) in which children experience a period of disorganization and regression which challenges parents’ skills and confidence in their practices (Brazelton, 1992). These occasions are
theoretically more problematic for parents who do not have a strong sense of efficacy. For mothers who feel competent in their abilities to parent, when the child finally reaches the milestone, the parent is likely to attribute some of this success to herself. Parents with a less developed sense of self-efficacy will adopt beliefs that the child persevered despite their poor parenting. It is not difficult to see how this cycle could continue and snowball. If the goal of preventing child maltreatment and supporting optimal child development is to be met, then effective parenting is key.

A focus on the essential role a woman plays, as mother, is important. Although empowerment may include economic independence, a dual spheres approach of the public world of male-dominated labor and politics and the private, female domain of home and family is neither practical nor helpful for women (Finn, 1998). For example, many recipients of home visitation services are single mothers. This creates an especially draconian position for them. If they conform to the female role of homemaker, they must utilize public monies for support resulting in labels of “lazy” or “freeloading” welfare clients (Zimmerman, 1983). If they work and leave their children to be “raised by daycare,” their own feelings of guilt are barely more pleasant (Brazelton & Greenspan, 2000; Mc Bride, 1973). Further complicating this idea are the home visitors who are mothers themselves dealing with both their own difficult decisions regarding work and home while simultaneously dealing with those decisions of their clients (Schafer, 1992). Rather than dismissing caregiving, feminism regards families and the important roles that women play in them as something to be embraced and engendered. Home visitors must be careful not to pathologize women in families. Traditional concepts of family often blame the mother, but a feminist approach takes notice of the mother's strengths and
builds upon them. Housework, caring and kinwork may traditionally be women's roles within the family and women may have filled these functions particularly well throughout history. This does not make these roles something to avoid in feminist practice, but can be accessed as strengths for the mother without being forced upon her.

From a feminist standpoint, everyone should be encouraged to develop as complete human beings. Empowerment cannot be given to a person. Rather, barriers should be recognized, reframed, or removed. Support and encouragement can be provided, but power should not be forced. It is important that empowerment is accomplished via collaboration and consensus. A therapeutic relationship recognizes the power differential of worker and client and attempts to create an egalitarian setting where both parties are valued and actively make decisions on treatment. Similarly, feminist research should recognize the power differential between the researcher and the study participants.

Researchers are individuals, male or female, who play an important role. They must be aware of the complicated interplay of values and practice. Personal and professional values emerge in what goals to set, questions to ask, and the relative value of methods and results. For example, Olds’ most recent research comparing nurses to paraprofessionals likely reflects his own experience within the medical model. Why this question? Why that particular comparison?

The role of home visitor and therapist from a feminist standpoint includes an additional burden. These professionals must also attend to the community and political context in which their clients live and be aware of the effect of public policy on mothers and themselves. Advocacy is not just a theoretical concept but also a truly important
aspect of practice in the world of political policymaking. Without this, workers will be tempted to “fix” each client's individual problems rather than eliminating social and political causes for the difficulties faced by many of their clients. Several items on Davis’ (1994) agenda for social work and building on women’s strengths are particularly relevant for practice with mothers: affordable, quality child care; better work and family coordination through flexible schedules; equal pay and improved policies to increase women's vocational choices and economic well-being; effective antipoverty strategies; and, national health insurance, child support enforcement and domestic violence policies.

Home visitors, as well as researchers, generally function within the context of larger organizations. They must be aware of the interdependence of their program and others (Senge, 1994). Organizations are constantly changing and the feminist worker must be aware of how these decisions reflect value choices. Just as home visitors are encouraged to respect diversity in their clients, they too must realize that diversity exists and should be embraced within each other.

Research Within Context

Research should be considered in its context. A program working from a feminist perspective must still face the issue of evaluation and researchers must conduct research for survival. Researchers and program managers must be aware of the historical and cultural contexts that have affected their research participants (Figueria-McDonough, 1998). Social workers and feminists have long applied their philosophy, ethics and values to practice, but have been less rigorous in applying them to research (Swigonski, 1994). Standpoint theory as an epistemology states that less partial and distorted
understanding of nature and social relations will result from research that begins from the standpoint of particular marginalized groups of human beings (Swigonski, 1994).

Research from a feminist standpoint is not purely theoretical. “Research must begin from concrete experience rather than abstract concepts” (Swigonski, 1994, p. 390). With the use of personal experience comes responsibility. Approaches to knowing must be guided by an ethic of caring (Swigonski, 1994). Home visitation programs often work within disenfranchised, underserved communities. Hence, particular sensitivity is needed to the invasive sort of efforts used in trying to document the effectiveness of interventions (McCoy-Thompson et al., 1994). Wolf (1996) describes her own feminist dilemmas in fieldwork. Despite her good intentions, she realized she was improving her own professional situation by utilizing the structures of poverty and gender inequality. Wolfe (1996) compares herself to a country doctor who, by working with the poor, has great freedom to study in a more thorough way than could not be accomplished serving more powerful groups. There may be a parallel analysis here for home visitation. There is a phenomenal amount of information collected on the poor women and children being served, for example, by the Olds Program. Yet, there is virtually no research on the home visitors, notably of a higher socioeconomic and political group than their clients.

Research Question

Child abuse and its impact on child development, including brain maturity and attachment, have been well researched. The economic advantages of preventing child maltreatment have also been articulated. Home visitation as an effective model of doing so has been shown by some research. The ability of home visitation to improve the
overall quality of care of children has been even better displayed. To date, no negative
impacts of home visitation programs have been discovered. The decision of whether or
not to implement a program is fairly clear. The role that one’s particular paradigm makes
on the decision of which type of program to implement has also been explored. The
elements of effective programs have been presented.

Home visitation with young children is not a young or new field. The past 25
years has seen rapid growth and expansion in this field (Eggbeer, Mann, & Gilkerson,
2003). Training initiatives have been refined and research and clinical models have been
developed (Eggbeer et al., 2003). Researchers have been exploring more closely the role
of supervision, training and fidelity of program and/or curriculum implementation in
successful outcomes (Baker, Piotrkowski, & Brooks-Gunn, 1999; Duggan et al., 1999;

Considering that generally only one person outside of the family is inside a home
on a visit, the role of that person is critical. There is already research showing the
effectiveness of home visitation programs staffed by a variety of professions. “Most
researchers believe it is not possible at this time to conclude that individuals from a
particular professional or educational discipline are better home visitors than others”
(Gomby et al., 1999, p. 18). An important and remaining question is what sort of
individuals make good home visitors? What qualities do they possess? How do they
grow and develop within that role? What values do they espouse about mothers and
children? What makes them effective with the challenging families with which they
work? Do they hold feminist values? These are relevant questions for which the field of
social work can provide answers.
“At the heart of the home visiting process and essential for its success is the helping relationship established between the home visitor and the client” (Wasik, 1993, p. 140). Hence, relationship skills are suggested as important (Keim, 2000; National Committee to Prevent Child Abuse, 1995b; Wasik, 1993). “While we know, in general, that the helping relationship is important in infant/family work, we still have much to learn about the details” (Korfmacher & Marchi, 2002, p. 21).

Furthermore, it is suggested that relationship-building skills should be present in the home visitor before hiring, rather than being taught in training (Wasik, 1993). “Interpersonal skills can be taught, but doing so is difficult” (Wasik, 1993, p. 148). Interpersonal skills are somewhat different from the other skills taught to home visitors such as weighing a baby, conducting a parent-child activity, or completing an assessment.

What is specifically meant by interpersonal skills? Although often mentioned, little elaboration is provided. Parents as Teachers (Parents as Teachers National Center, 1999) defines interpersonal skills as enthusiasm, confidence, non-judgmental attitude, respect, and compassion. These things are not really skills but personal characteristics. Enthusiastic describes a type of person or a personal trait more than a skill to be mastered. Although behavior changes in situations and over time, a general approach to other people is fairly stable over life (Tieger & Barron-Tieger, 2001). For example, people tend to more enjoy being with others (extravert) or spending time alone (intravert).

Very little research has been done on the home visitors themselves. The available descriptions related to characteristics of home visitors offers scanty information beyond vast generalizations. Healthy Families America suggests providers should be selected
because of their personal characteristics like compassion and ability to build relationships (National Committee to Prevent Child Abuse, 1995b). There is much more to be learned.

Home visitors are the lynchpin of child abuse prevention. Just as the potential of a child is enormous, so is the potential of home visitors to impact the family, and in turn the child, in meaningful ways. From the child’s perspective, their view of the world can be significantly altered if they receive nurturing care from an effective and supported caretaker. Home visitors help parents become responsive caretakers. Since the ultimate goal of intervention is the child’s overall positive experience of the world, the benefit is for us all. Hence, we have come full circle. “The fact that many of our children do not reach their potential is a triple tragedy- a lifelong tragedy for them, for their families and for our society as a whole” (Zero to Three, 1992). The capacity for children to reach their potential offers a benefit for them, their families and all of society.

I propose that there is a gap in the research on preventive home visitation that can be filled in a meaningful way by and for social work. This is an examination of the personal characteristics of effective home visitors. Research within the field of social work can be respectfully represented within both a post-positivist paradigm and feminist theory. According to Collins (1986), “social work is fundamentally feminist in nature” (p.214). In congruence with social work values and feminist theory, the worth of individuals as home visitors is recognized. From the paradigm of post-positivism, research using mixed methods is suggested. By involving said home visitors in the research, a richer picture will be drawn. This information will profit those making policy and programmatic decisions. But more importantly, it will benefit children.
Chapter 3: Research Methods

Rationale for Choice of Methods

The research methods were chosen for their ability to address the question: What are the personal characteristics of home visitors? A mixed methods design was chosen to allow themes, grounded in the data, to emerge that are both reflective of and enlightening to the field of home visitation. Data collection included: (a) focused interviews with home visitation administrators, (b) demographics of home visitors, (c) open-ended interviews with home visitors, (d) home visiting situational vignettes, and, (e) quantitative tests of personality attributes.

The choice of a mixed design, incorporating qualitative methods, stems primarily from the nature of the research question. A mixed methods design provides the combined strengths of both quantitative and qualitative methods and offers complementary insights. Multiple methods of data collection supply triangulation. From a post-positivist paradigm, flawless research is impossible (Guba, 1990). Decisions are constantly being made to maximize (and in turn minimize) the interdependent aspects of the inquiry process. Values play a role in such decisions so should be articulated (Glesne, 1999). The combination of rich, deep data with critical multiplism for balance appealed to this researcher.

Creswell (1998) offers guidelines for the choice of qualitative methods. The initial consideration is the nature of a question. In this case the question, “what are the personal attributes of home visitors?” involves asking “what” instead of “why.” Questions that ask “what” can be best answered by qualitative methods (Creswell, 1998). The goal of this research was understanding rather than prediction (Royse, 1991).
Secondly, qualitative methodology is best for a topic that needs to be explored (Creswell, 1998). This research area had miniscule information available. A few vast generalizations were available but a close up view was lacking. An in-depth exploration of the personal characteristics of home visitors was needed. Deep exploration lends rich detail in congruence with Creswell’s (1998) third rationale for qualitative study- a need for a detailed view of the topic.

Additional reasons for choosing a mixed methods design that includes a qualitative approach reflects the researcher’s epistemological stance. Creswell (1998) states that a key reason for qualitative methodology includes a researcher who wants to emphasize his/her role as an involved student in the process. It was more personally congruent for this researcher to see herself as an active learner or party to the process, rather than as the detached and knowing researcher. Feminist theory stresses research conducted within context, being sensitive to the role of researcher and participant and the potential impact of findings. It would feel dishonest to this researcher to present oneself as a detached researcher and outsider to the field.

Home visitation programs that support the growth and development of children do so through the home visitor’s empowerment of their mothers. In a parallel process, this researcher supported the growth and development of home visitors through empowering research processes. The home visitors play an integral role in the field of home visitation and can contribute to the research endeavors within it. It is useful for home visitors to play a more active role in the research on home visitation.
Sampling Design

Given the qualitative aspects of this research, a small, non-random, purposive sample was used. In order to better understand the personal attributes of effective home visitors, an extreme sample of outstanding home visitors was utilized. A description of the ideal represents a first step into describing the personal attributes of home visitors. In order to discover the personal attributes of effective home visitors, a study of outstanding home visitors using mixed methods was chosen.

In order to locate outstanding home visitors, administrators of preventive, early childhood, home visitation programs within the greater Cincinnati area were contacted. Since research is just beginning on what makes a home visitor effective, home visitation administrators were asked for their recommendation of their best home visitor or visitors (one or two) to participate in the study. These recommended participants were the best in their program according to the administrators. It was believed that such a sample would provide a beginning image of what makes some home visitors excel and stand out. The similarities in those home visitors could be explored without attempting to define excellence across various programs and models of home visitation.

Administrators of home visitation programs were located via umbrella organizations for home visitation in the greater Cincinnati area (Ohio Help Me Grow, Every Child Succeeds). Both Olds and other programs (HFA and similar) were represented. No efforts were made to control for the stated professional training of the participants. This targeted sample, those identified as outstanding in their area, could include social workers, nurses, or paraprofessionals, as long as they were the best in their agency. Administrators agreed that this singling out would not be divulged to the home
visitor. The home visitors who had excelled in that role offered the best data with which to begin. Rather than look at a large number of home visitors, the researcher examined the best home visitors which offered an analysis of the ideal. Interviews continued until saturation.

Data Collection

Data collection for this research included: (a) focused interviews of home visitation administrators, (b) demographics of home visitors, (c) open-ended interviews with home visitors, (d) home visiting situational vignettes, and, (e) quantitative tests of personality attributes.

Focused Interviews of Administrators

Home visiting program administrators were contacted in order to identify outstanding home visitors for participation in this research. Administrators were asked to recommend their best (one or two) home visitors. The only criteria the researcher offered was that the recommended home visitor(s) be “seasoned” home visitors- those doing the work for at least one year. This ensured that all home visitors in the study had at least a basic knowledge base by having completed their core or initial training in their respective model of home visitation. The umbrella organizations (Help Me Grow and Every Child Succeeds) require home visitors to complete certain home visitation trainings within their first year. These requirements have changed over time so the chosen home visitors did not necessarily complete the same required trainings as one another. But, at least all
participants had completed the trainings the umbrella organizations viewed as representing the minimum knowledge base required for home visitors at that time.

Nine supervisors from two states (Ohio and Kentucky) were interviewed. All agreed to participate but most preferred to not be audio-taped.

The questions were:

- Can you tell me who is your best home visitor or home visitors?
- Was that easy to answer, why or why not?
- Tell me about what you think makes this person an excellent home visitor?

Administrators were assured that the researcher would not tell the home visitor(s) that they had been singled out for their excellence.

Although the criteria used by the administrator for identifying their best home visitor(s) was not determined by the researcher, the criteria the administrators actually employed was useful information and assisted in triangulation of data. To collect that information, focused interviews were used and conducted either in person or via the telephone.

**Demographics of Home Visitors**

All ten recommended home visitors agreed to participate. Interviews took place from May to November of 2006. Most were conducted at the home visitors’ office with the exception of two that were completed at a local restaurant per the home visitor’s request. Participants received no additional compensation for the interviews but completed them during work hours with the approval of their supervisors.
A short data collection form was used to collect basic demographic information about the respondents. Along with the vignettes, the initial “paperwork” provided a gentle warming up to the subject of their work as home visitors. Vignettes, interviews and tests were connected to the demographics by a simple ID number (number of respondent). The following demographic information was collected:

- Work experience (years as a home visitor);
- Current and past caseload type, size, and area;
- Educational background (field of education, years of education, highest degree held);
- Personal demographics (age, race with which the home visitor most identifies, ethnicity with which the home visitor most identifies, parenting status).

The resulting sample consisted of 11 home visitors including the initial pilot interview (three nurses and eight social workers). Two of the nurses were in the Olds program and the rest worked in programs that could be considered HFA approaches. The pilot interviewee was a nurse who had recently left the field but whom the researcher had worked with and respected. There was no corresponding supervisor to the pilot interview and her demographic information is not included here. The participants had 1-31 years of experience with an average of 7 years. All were female and all identified as Caucasian. The average age of the home visitors was 42.7 years with a range of 26-58 years (See Table 3).
Table 3: Participant Demographics

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Age (in years)</th>
<th>Educational Background</th>
<th>Number of children</th>
<th>Caseload</th>
<th>Program Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>36</td>
<td>BA(LSW)</td>
<td>3</td>
<td>20</td>
<td>HFA</td>
</tr>
<tr>
<td>2</td>
<td>54</td>
<td>BSN</td>
<td>4</td>
<td>26</td>
<td>NFP</td>
</tr>
<tr>
<td>3</td>
<td>36</td>
<td>BA (LSW)</td>
<td>0</td>
<td>28</td>
<td>HFA</td>
</tr>
<tr>
<td>5</td>
<td>50</td>
<td>BSN</td>
<td>1</td>
<td>40</td>
<td>NFP</td>
</tr>
<tr>
<td>5</td>
<td>29</td>
<td>MSW</td>
<td>0</td>
<td>23</td>
<td>HFA</td>
</tr>
<tr>
<td>5</td>
<td>58</td>
<td>BSW</td>
<td>2</td>
<td>27</td>
<td>HFA</td>
</tr>
<tr>
<td>6</td>
<td>56</td>
<td>BSW</td>
<td>3</td>
<td>42</td>
<td>HFA</td>
</tr>
<tr>
<td>6</td>
<td>26</td>
<td>BA</td>
<td>2</td>
<td>33</td>
<td>HFA</td>
</tr>
<tr>
<td>6</td>
<td>30</td>
<td>BSW</td>
<td>0</td>
<td>41</td>
<td>HFA</td>
</tr>
<tr>
<td>31</td>
<td>52</td>
<td>MSW</td>
<td>2</td>
<td>20</td>
<td>HFA</td>
</tr>
</tbody>
</table>

Open-ended Interviews of Home Visitors

Face-to-face, in-depth interviews consisting of open-ended questions were conducted. No compensation was offered. A Lay Summary was provided to the visitor in order to enhance their understanding of the process and confidentiality (see Lay Summary section). Several prompting questions were used to encourage the home visitor’s discussion of their experiences.

- What do you like about your job?
- What do you think makes you good at it?
- What do you dislike about this job?
- Describe for me your best home visit.
- Describe for me your approach to families and children.
- Has your approach to families, children and home visiting changed since you started?
- What is the most important thing a new home visitor needs to know?
- What is the most important skill a new home visitor needs to have?
- What is the most important value or attitude a new home visitor needs?
- Tell me about how you view the women and children you work with in relation to society.
- Where do you see yourself professionally in 5 years, 10 years?
- Tell me about stress in this job and how you handle it.
These interviews were audio-taped and transcribed verbatim so as to avoid bias. The initial interviews were transcribed in their entirety so the important or relevant aspects, previously unknown, could emerge.

Vignettes

Five situational vignettes were presented to each research participant. These short vignettes offered insight into how home visitors handle situations that they may have or could encounter in their work with families. The vignettes also offer a more structured form of data collection to complement the open-ended interviews. It was intended that the home visitors would respond to these vignettes in writing; however, their responses were also audio-taped. This was especially useful in documenting the home visitor’s answers to follow-up questions and the discussions that often ensued from the vignettes.

The vignettes were written to elicit concrete details of how home visitors handle specific situations while on home visits. This provided a picture of the practical application of how they express themselves in their work with families and furthered triangulation. While the interviews shed some light on how they approached circumstances, the vignettes illuminated the specific behavioral expressions of their underlying values. The vignettes also spawned additional questions for the interviews with an immediate opportunity to clarify responses as needed. The vignettes offered the opportunity to view how some home visitors might naturally handle situations even if they were not conscious of the theory underlying their approach. It is possible that some home visitors approach their work in the field very naturally- a reflection of how they relate to anyone. Since we are assuming that their approach works as they are recognized
by administration as the best in their program, this is meaningful data. Furthermore, the concrete details of an example helped elicit this strength.

The particular situations were chosen to address several themes that appear relevant but may be more likely to elicit contrived responses in an interview. For example, if the interviewer asked a respondent if she goes beyond her traditional role, the response may reflect what they perceive as an expected or appropriate response. By presenting a vignette that offered an example of going beyond their role in a positive situation (celebration) and negative situation (housecleaning), a deeper understanding of role perceptions was gained. The additional vignettes were written to address applied feminism, empathy, and relationship. The following vignettes were presented to the respondent:

- You arrive for a visit with a client you have been seeing for 3 months. She excitedly gives you an invitation to her baby’s Christening and asks if you can come. Assuming you are free that date, what would you say?
- You arrive at a visit with a client you have only been seeing for about a month. She is frantically cleaning up for an inspection from the housing authority in 20 minutes. She is busy tidying and is worried that she won’t have time to clean the oven and stovetop (covered with old food spills). She tells you she knows the housing authority has been using this to evict people lately. Do you help her? Why or why not? What words do you use?
- On your last three visits your client has had emergency crises that have taken up the whole visit. Today when you arrive, she tells you that she is going to be evicted today and has nowhere to stay tonight. Describe how the visit might go.
- One of your clients is a single mom on welfare with a new baby. While discussing her goals, she tells you what she really wants to do more than anything is to stay home and raise her baby and she would like to make her goal to find a way to do this. How do you respond?
- A mom you have been working with has unexpectedly not been at home for your last three visits. Today she is at home when you arrive. What, if anything, would you say about the missed visits? Why would you say that?
Personality Scales

Two quantitative tests of personal attributes were also completed by each home visitor. These tests were chosen based on their applicability to the general suggestions located in the existing literature that home visitors possess interpersonal, relationship-building skills.

Interpersonal skills are not uniquely helpful to home visitors. The meager recommendation that prospective home visitors possess interpersonal skills is so general as to be a suggestion that could be made for virtually all jobs that involve personal interaction (i.e., car salesman, fast food service worker, convenient store manager, etc.). Interpersonal skills such as enthusiasm, confidence, non-judgmental attitude, respect, and compassion are in fact personal characteristics more than skills and although behavior changes in situations and over time, a general approach to other people is fairly stable over life (Tieger & Barron-Tieger, 2001).

Home visitation programs recognize the importance of the relationship that occurs between client and home visitor (Glink, Stott, & Eggbeer, 2000; Keim, 2000; Wasik, 1993). “The relationship between advocate and client is central to the success of the intervention, because it is the path through which change occurs” (Grant, Streissguth, & Ernst, 2002, p. 19). The important labor of building and maintaining that therapeutic relationship is primarily the work of the home visitor, not the client. In order to facilitate relationship-building, several sources suggest looking for empathic people when hiring home visitors (Glink et al., 2000; Kumpfer, 1999; Wasik, 1993). But, how does one know if a potential home visitor is empathic? Is empathy a trait typically expected or assumed in persons from helping professions, especially those traditionally held by
women (nursing, teaching, social work, counseling)? Are good home visitors more empathic than others? Is it helpful to be extremely empathic? It is unlikely that good home visitors are simply those that are empathic all the time. Korfmacher and Marchi (2002) ask if it is enough to be empathic “or does the practitioner need to keep a delicate balance of empathy and objective distance, walking the narrowly appropriate path of engagement?” (p. 22). “While we know, in general, that the helping relationship is important in infant/family work, we still have much to learn about the details” (Korfmacher & Marchi, 2002, p. 21).

This researcher found no literature in which such instruments were used with home visitors. Characteristics noted as useful for home visitors appear to have been based on observation or theory. It was hoped that a paper-and-pencil test of said attributes would help to clarify and quantify such ideas as well as provide an opportunity for further triangulation of the data. The two instruments are the Balanced Emotional Empathy Scale and the Myers-Briggs Type Indicator (Mehrabian, 2000; Myers, McCaulley, Quenk, & Hammer, 1998).

The Balanced Emotional Empathy Scale

Literature suggests that empathy is a necessary trait for a home visitor’s relationship-building with their client. Empathic people were raised more warmly and affectionately, are less abusive to children, and are pleasant to be around (Mehrabian, 2000). Empathic people are said to be more “interpersonally positive, affiliative, and adept” (Mehrabian, 2000). Since such descriptions sounded like excellent home visitors,
it was worth exploring if empathy is the trait that underlies some of the interpersonal skills mentioned in the literature.

The Balanced Emotional Empathy Scale (BEES) was designed to measure the personality characteristic of being able to feel what another person feels (Mehrabian, 2000). This 30-item instrument takes about ten minutes to complete (see Appendix A). Statements that reflect feelings and situational responses of empathy are presented (i.e., “unhappy movie endings haunt me for hours;” “I have difficulty knowing what babies and children feel”). Respondents then rate their level of agreement or disagreement on a nine-point scale. Questions are worded positively and negatively to reduce acquiescence response bias. Norms are available (means and standard deviations by sex) for comparison.

The reliability (internal consistency) of the BEES was established by Mehrabian (Mehrabian, 2000) with an internal consistency coefficient alpha of .87. Its validity is supported by a positive correlation (.77) with an earlier empathy scale called the Emotional Empathic Tendency Scale developed in 1972 and by subsequent research showing that persons who measured high on the BEES also:

- had higher skin conductance and heart rate to emotional stimuli,
- were emotional as evidenced by their tendency to weep,
- had parents who had spent more time with them, displayed more affection, and had been more explicit verbally about their feelings,
- were tolerant of infant crying and less abusive toward children,
- had altruistic behavior toward others and volunteered to help others,
- had highly affiliative experiences,
- were non-aggressive,
- rated positive social traits as important,
- had higher scores on measures of moral judgment,
- were arousable and had pleasant temperaments (Mehrabian, 2000).
For the purposes of this study, individual and group scores were compared to the norms available for women. The researcher expected that the excellent home visitors would be higher in empathy than the general population norms.

*Myers-Briggs Type Indicator*

If personal traits are stable over time, can the personalities of the outstanding home visitors be categorized? Do stellar home visitors tend to have similar traits as measured by a commonly utilized measure?

The Myers-Briggs Type Indicator (MBTI) is a personality inventory that has been widely used throughout the 20th century (Quenk, 2000) (Appendix B). It is based on the work of Carl Jung and the subsequent application of his writings by Katharine Briggs and Isabel Briggs Myers (Quenk, 2000). Personality Type offers four dimensions (continuums) representing how a person prefers to interact with the world, the kind of information naturally noticed, how decisions are made, and whether they prefer to live in a more structured (making decisions) or spontaneous way (Tieger & Barron-Tieger, 2001). These continuums are: 1- the extraversion-introversion dichotomy; 2- the sensing-intuition dichotomy; 3- the thinking-feeling dichotomy; and, 4- the judging-perceiving dichotomy (Quenk, 2000). There are advantages and disadvantages to each aspect and people can function very effectively in all of the MBTI dimensions. Personality Type is being used to help people find the specific type of work they will most enjoy and at which they can excel (Tieger & Barron-Tieger, 2001). The researcher suspected that since participants were all excelling in home visiting, they would be of similar personality type.
Extraverts are energized by being around other people, communicate their enthusiasm to others, and are easier to get to know. Extraversion includes some of the characteristics used to describe interpersonal skills. Are good home visitors extraverts? It may seem so but extraverts also talk more than they listen. Introverts are energized by spending time alone and keep their enthusiasm to themselves, but they are good listeners. Communication skills for relationships involve both listening and talking.

Reliability testing of the MBTI has continued steadily since 1965 (Quenk, 2000; Ring, 1998). The reliability of this instrument is the topic of numerous studies (Myers & McCaulley, 1985). Studies utilizing the MBTI data bank of over 9000 tests have found internal consistency coefficients based on coefficient alpha ranging from .76 to .83 (Myers & McCaulley, 1985). What may be important to note here is that the reliability of the MBTI is “as good or better than other personality instruments” (Center for Applications of Personality Type, 2003).

The validity of the instrument is no less researched or discussed. Perhaps the strongest support for the MBTI’s construct validity are the correlations for preferences with the Jungian Type Survey, developed completely independently of the MBTI (Myers & McCaulley, 1985). For our purposes, it is important to note that construct validity has been established by showing a significantly higher percentage of certain types in certain areas of interest (such as occupational interests) than could be expected by chance (Center for Applications of Personality Type, 2003).
**Pilot Testing**

The data collection methods were piloted with a home visitor. Piloting provided feedback on the interview as well as the entire data collection process. This piloting served several purposes. First, the pilot interview and testing supplied an accurate measure of the time taken to complete data collection (approximately 1 hour). Secondly, feedback on the content and wording of the Lay Summary was attained. Thirdly, the pilot home visitor was asked to assist the researcher in refining the interview and vignettes. Following the proposed interview, the pilot interviewee responded to the following queries:

- Did any questions make you uncomfortable?
- Were any too vague or left you unsure about what I meant?
- By looking at these questions, do you have any suggestions about wording changes or order changes?
- How do you think other home visitors would respond to this process?

The pilot interviewee responded positively to each of these questions and found the vignettes to be representative of seasoned home visitors’ experiences. Since no constructive criticisms on the questions, vignettes, or process were offered, no changes were made from the original proposed data collection plan.

**Data Analysis**

Analysis of qualitative data is an on-going process occurring simultaneously with data collection (Glesne, 1999). The transcribed interviews, demographics, responses to vignettes, and personality testing results offered a large body of data with which to pose
propositions. Propositions that arose in the course of data collection were tested with subsequent participants. Additionally, field notes, memo writing, and electronic files were used.

Field notes were used to recall important observations and interpretations in the course of data collection. Field notes were typed and included with memo writing or journaling of ideas and observations throughout the process to assist with the ongoing data analysis. Electronic files (primarily in Microsoft Excel) were used to organize data storage and demographic information.

Qualitative research software (NVivo 7) was used to assist in the data analysis of the interview transcripts, situational vignettes, administrator interviews and interviewer’s notes. Open coding is a process of analyzing data by breaking it down into categories and subcategories that are compared for similarities and differences (Creswell, 1998). Initial open codes were followed by axial codes where connections between categories and subcategories reconstructed the data in a new way, allowing further categorization, synthesis, and interpretations to follow (Creswell, 1998).

The tests of personal attributes were analyzed somewhat differently than the other data. Individual and group scores on the BEES were compared to the norms and standard deviations for women. Results indicated how individual home visitors and this group of outstanding home visitors compared to general norms in this measure of empathy. With the MBTI, the categorical data of individual dimensions, temperament groups, and dominant functions was examined for similarities across the individuals in this group of home visitors.
Validity Issues

Within positivist research the verification issues of validity and reliability to be addressed by a researcher are fairly clearly established and have been presented for the BEES and MBTI. Within qualitative inquiry, trustworthiness is used to attest to the quality of research (Glesne, 1999). Two aspects of trustworthiness in qualitative research include credibility and transferability.

Credibility

Credibility is similar to the quantitative aspect of internal validity and is used where the relationship between two variables is not being measured in a positivistic way (Guba & Lincoln, 1989). Credibility refers to how believable the findings are and how well the researcher constructs reality based on the constructed realities of the participants (Guba & Lincoln, 1989). In this study, credibility was established by prolonged engagement, persistent observation, and member checks.

Prolonged engagement refers to the length of interaction between researcher and participants (Guba & Lincoln, 1989). This test is met by the in-depth interviews and further triangulated by the additional information gathered from the administrators, vignettes, and personality testing. Persistent observation is necessary to tease out the most important aspects of the issue being studied (Guba & Lincoln, 1989). In this case, the triangular methods and continuation of the process until no new information was gleaned should adequately represent prolonged engagement.

Finally, member checks were utilized by discussing emerging theories with interviewees providing an opportunity for the research participants to correct errors in
interpretation, providing additional information or elaboration, and confirming individual data items (Guba & Lincoln, 1989). Guba and Lincoln (1989) report that member checks are “the single most crucial technique for establishing credibility” (p.239).

**Transferability**

External validity or generalizability is better represented by transferability within qualitative methods (Guba & Lincoln, 1989). Transferability occurs by describing the context fully so that sufficient information is provided for the reader to decide if the findings are applicable to their setting. Utilizing “thick description” allows the reader to determine the applicability of results to their own setting (Denzin, 1989). Thick description should result in the receiver of the information being able to ascertain the time, place, context, and culture of the propositions and to draw conclusions regarding how similar they are to others in which they have interest (Guba & Lincoln, 1989).

**Protection of Human Subjects**

There was minimal threat to the participants of this research. Approval for the study was granted through the Indiana University Purdue University at Indianapolis Institutional Review Board (Appendix 3). A “Lay Summary” was provided to participants for the purpose of fully explaining the role of the researcher and participants in the project. Lay summaries are useful for preparing the participants “to take part most effectively in data collection” (Glesne, 1999, p. 35). The following lay summary was given to potential participants.
Lay Summary

You are invited to participate in a research study to learn about the personal characteristics of home visitors. This research is being done as part of my doctoral studies at Indiana University’s School of Social Work.

Through this study you can help me better understand why you are good at what you do. You can benefit by learning more about yourself and your skills as you go through this process. The field of home visiting can benefit by gaining knowledge about what makes good home visitors.

As part of your participation in this study, I will interview you. This interview will be tape recorded so that I am sure to get all that you say correctly. You will also be asked to respond in writing to 5 situations that you have or may encounter as a home visitor. This will help me see how you work in the field without going on a real visit with you, which would involve intruding on your clients and their privacy. Last, I will ask you to complete a test of personality traits. This is to see if the home visitors participating are alike in any meaningful, measurable ways.

Your participation should take about 2 hours. I will likely call you at some later time to check my understanding of what you said or ask you what you think about some emerging ideas I have formed. If your responses are used in any writings on this study, your identity will not. I hope this helps you feel like you can answer honestly because there are no right or wrong answers in this study.

Your participation is entirely voluntary and you can quit at anytime or decline to answer any item with which you are uncomfortable.
Researcher Subjectivity

In congruence with post-positivism, this researcher feels it is necessary and helpful to state the limits of her subjectivity. This research topic was strongly affected by my social work field experience as the director of a home visitation program. Data analysis was more removed since data collection did not commence until after I had left the field of home visitation and was working in academia.

For eight years I was the Home Visiting Director of the Butler County Help Me Grow Program. Within this position, I implemented both an Olds program and one congruent with Healthy Families America’s characteristics. I met Dr. Olds and worked with his training and implementation staff directly. I participated in the Healthy Families America’s Research Practice Council and knew each director of HFA from 1998 to 2006. By the time I began collecting data, I had no involvement in the field of home visitation.

From my field experience, I perceived that many program administrators and researchers were examining model implementation in home visitation, utilization of curricula in visits, and supervision and training of visitors. Yet, no one had examined how you pick the great staff that then carries out all these tasks. I have discussed this topic at every possible opportunity with others in the field and it has been very positively received. The response is typically, “we’d love to know that.”

Although many suppositions mentioned thus far are supported by the research presented, the following are still assumptions I hold and should be stated.

I do not think profession is as important as personal characteristics for a good home visitor. I have worked with home visitors of all professions and paraprofessionals and have found good and bad ones in each group. Earlier, much of the debate on home
visiting focused on professional versus paraprofessional workers (Gomby et al., 1999). There is no research comparing nurses to social workers or social workers to paraprofessionals in home visitation. Being cognizant of the responsibility of the potential impact of any research, this would not seem the best pursuit for the field of social work. It is more congruent with social work values to engage in a proactive rather than a divisive response to this research.

I think the home visitor is the key in this whole process. This is not to say that training and supervision are not critical. They are. It is just that they come together in a person who is out in the field all day every day by themselves. The home visitor is often the only person in an organization who ever has direct contact with the client. The home visitor becomes a gatekeeper of sorts in determining what information and activities they bring to the client and what information they bring back to the agency and supervisor.

Because the home visitor is “alone” in the field virtually all the time and in people’s houses intimately, their role is a bit fuzzy. Going beyond one’s traditional role is a training topic. However, an overly flexible role (“friend”) is probably equally as problematic as an overly strict one. Roles need to change with different clients as well as with client needs and the stages of relationships between clients and home visitors. It is not clear how good home visitors know where to draw that line.

Finally, I think that implementation of education and training is flavored by the individual’s characteristics. Unless scripted word for word, visits using the same protocols will look and feel different.

In the process of contacting supervisors and home visitors for interviewing, I ran across a few people I had met when working in the field of home visitation. Our previous
meetings may have assisted in the enthusiasm of two supervisors and one home visitor to participate but the process of selecting home visitation supervisors who then choose the home visitors for this research occurred as laid out in this document. I did not interview supervisors from the program in which I had worked.
Chapter 4: Results

Data Reduction

Administrator Interviews

What criteria did the supervisors use in choosing their best home visitor(s)?

Organizational skills, relationship building skills, ability to work independently

Administrators were asked how easy or difficult it was for them to choose a “best” home visitor. All agreed that a person or two immediately came to mind and there was consensus as to what made this home visitor stand out to the administrator.

Virtually every supervisor immediately mentioned their recommended best home visitor was organized and this contributed to their success. Like many jobs, home visiting includes measures of productivity. Home visitors go out into the field and do their work with families and then must document their efforts. Significant organizational skills are required to stay on top of the abundance of forms, data entry, and planning necessary for home visiting. Some supervisors mentioned that they prefer someone who is good in the field and in interacting with clients over a home visitor only good at paperwork but to have both skills in the same home visitor was viewed as a blessing by the supervisors. Their best home visitor had both.

Supervisors recognized that it was critical that home visitors be skilled at building relationships with clients because this is a boon to program income. Home visitors who form good relationships with their clients have higher rates of productivity including high rates of client enrollment and retention.

The majority of supervisors described their chosen home visitor as standing out in their ability to work independently. The home visitor’s day is spent in the field and
they are responsible for planning and scheduling their own time in addition to making a myriad of decisions on their own in the field on a daily basis. Other terms used by the administrators to describe this trait included “self-disciplined” and “takes initiative.” One supervisor provided the following analogy: “home visitors are like outdoor cats. They thrive in a loosely organized environment. They are independent (and) don’t need a lot of structure.”

Other criteria noted by a minority of supervisors included the home visitors’ ability to implement curriculum and think creatively or “outside the box.” The home visitor’s maturity and empathy were also mentioned by some administrators.

**Home Visitor Interviews**

*What did the home visitors think made them good at their job?*

*Non-judgmental attitude, their approach to families, ability to form relationships with clients*

Every home visitor mentioned at some point that they felt they were open-minded and non-judgmental and that these qualities were critical to their success. The ways the home visitors said they expressed this trait to their clients included their body language and their approach to families. Although a few social workers mentioned that training in social work contributed to this non-judgmental attitude, all felt this was a natural part of their character that came from their background, experience in working with different kinds of people, and probably preceded their interest in a helping profession.

The home visitors described very similar approaches to the clients they serve. Their approach could be described as quite humble towards their role in helping their
clients even though they strongly believed they were making a difference in the lives of the moms and babies. The home visitors were constantly cognizant that they were guests in their clients’ homes. They viewed themselves as bearers of information and the parents as the expert on their child. The home visitors described an almost laid-back approach to home visiting where they follow the client’s lead. They go into a visit prepared for a particular topic but are able to follow the parent or child in another direction as needed. This allows the home visitor to celebrate the client’s successes but not feel responsible for their failures and poor decisions. As one described it, “This is their life, their journey and they can make the choices that they want and I just help support them to make those choices.” Ironically, this detachment leads them to better relationships with their clients.

The second quality that home visitors consistently mentioned as assisting them in their work was that they were good at building relationships with their clients. Relationship-building was a quality found in the administrators’ comments as well. Again, some home visitors felt that their social work education may have helped them in building rapport, but that this was a skill they always had. All said they were just really good at forming relationships with people and always had been.

And that part in life for some reason is just something that…I’m not trying to ring my own bell or anything…but just something that I tend to be good at. It tends to be easier for me than some people. Some people have a harder time forming relationships. I seem to be able to do that quickly and that’s just something that I’m tuned into or something and so it just works for me. So I don’t know exactly how I seem to be able to do it; to connect, but it just seems to work and I wish I could tell you what exactly makes that happen but I do seem to be able to do the relationship-forming part of it.
The home visitors recognized the importance of building rapport with their clients. They also mentioned that it needed to be accomplished quite quickly.

This job is a lot about relationships and I’m not going to be able to get in the home and give out parenting information and developmental information if I am not able to have a relationship with this woman and she doesn’t want me there.

The ways they were able to build rapport quickly included actively listening, enjoying the moms and kids, and being comfortable in any home environment. The home visitors felt that their relationship with the mothers was the key to the rest of their work. As one respondent stated, “The relationship precedes everything else.”

It is worth noting that there is overlap in the qualities that home visitors felt made them good at their work and the criteria used by the administrators in choosing their best home visitor. Both focused on the relationship between home visitor and client but for slightly different reasons. Administrators saw the relationship as critical for the home visitor’s productivity while home visitors focused on the relationship as a means to impart information to the client. Understandably, the administrators were more focused on organizational skills and the home visitor’s ability to work independently due to the effect these qualities have on administrative issues such as productivity and supervision.

The home visitors felt that their non-judgmental attitude, approach to families, and ability to form relationships with clients were the qualities that made them better able to do their work. The perceptions of these home visitors are congruent with the existing literature in recognizing the importance of the relationship between home visitor and client (Keim, 2000; Korfmacher & Marchi, 2002; Wasik, 1993).
What did the home visitors think was a good home visit?

Parent involvement

The participants’ descriptions of an ideal home visit were quite consistent and, surprisingly, had little to do with what the home visitor specifically did or planned for that visit. Instead, the focus was on the client and “making it all about them.” Good home visits were when the mother interacted with her child with enthusiasm, ideally down on the floor. The mom’s active participation in the visit included showing interest, signs that they grasped the concepts presented, actively listening, and asking questions. The overall tone of the visit is positive. Good home visits often include the father as well. Ideal home visits were not something they felt they exactly controlled but rather a time of collaboration with the parents.

What attitudes, skills or knowledge did the home visitors feel someone going into the field should have?

Tolerance, respect for mothers, counseling skills, organizational skills, patience

The participants struggled with the differences between attitudes, skills, or knowledge and gave overlapping answers for each. It is possible that these are not orthogonal categories. Still, the responses consisted of similar content.

The respondents described good home visitors as tolerant of all kinds of environments. Even in unpleasant home environments, the home visitors worked hard to put their values and background aside and not judge the clients for their living situation. They acknowledged that some living conditions did, at times, make them uncomfortable, but at those times they would practice tolerance and be careful about their verbal and
non-verbal language. As one home visitor put it, “I say to myself well, if they can live there then I can visit.” Another stated, “the smells and odors in the home shouldn’t prevent you from speaking to them as you would somebody else who had a home and garden home.”

This tolerance included a genuine respect for family differences. This respondent framed it as being truly respectful of cultural differences.

I think it’s respecting all kind of people in terms of differences and backgrounds and kind of the most broad cultural diversity you can think of… not just race or ethnicity but the culture of this family is that you never wear shoes or … really being able to understand your own culture and where you came from but not force that on anyone else.

A second attitude home visitors felt necessary was a general respect for the job of raising children. The home visitors saw the efforts of these generally poor, young mothers to raise their children as the most important thing they do. Many of these mothers were viewed by society as having made a mistake in having a child out of wedlock. One home visitor stated “(You) need to value mothers and children.” One home visitor explained it as:

I believe that children have the right to a happy family life and that mothers have the right to a happy family life and that that’s what’s really important and that you are helping that to happen. Then you feel good and want to do it if you believe in it. And that’s definitely what I believe in. Children and mothers have the right to wake up together and feel safe and cozy and warm and happy and have something to look forward to- to feel safe.

Another stated, “you need to believe in what you are doing, obviously, or you just kind of go out there and spew information.”
This humble attitude towards their role in making significant changes in the lives of the women and children they served was visible to this interviewer. One home visitor tied all the useful attitudes thus far discussed into the following quote:

I think it’s that you are going into someone else’s home and you need to be…you need to build rapport with that person. You need to not go in there trying to be the expert and the all-knowing. It really is about relationships. Really so much about everything everybody does in the world really is about relationships and how can you get anywhere if you don’t have the ability to form a relationship with someone?

When asked about skills, home visitors typically mentioned basic counseling skills as beneficial for the job, specifically listening skills.

It’s not just hearing what people are saying. It’s knowing and understanding and being able...sometimes with the new moms it’s not that they need someone to come in and solve their problems or tell them how to be a good mom. It’s listening to what’s going on in their life just so they can get it off their chest. And I think that that helps build rapport a whole lot better with the moms. And helps establish a relationship where they know they can trust you to listen to their problems without giving them advice all the time. Where like their parents in their lives will tell them “You need to do this! You need to do that! You need to do this!” Where we are just somebody sitting back saying “how does that make you feel?”

Several of the social workers felt they had an advantage over professionals from other educational backgrounds because they came into the job with some training in counseling skills including asking open-ended questions and reframing. These skills helped the clients feel listened to rather than “being preached to.”

You get a lot (of training in counseling skills) in social work. Here at this agency we really work with nurses, early childhood education and through that process I’ve really learned that that is a skill that helps in home visiting because they struggle more with that.

Others felt that these skills were not that amenable to being taught.
I think a lot of it is just good communication skills. There is no magic way to build relationships with people but good training on how to develop relationships with people. But, you know, at the same time I don’t know if there is a training for that. Sometimes I feel like that’s almost who you are, if you are able to really do that with families. I don’t know. It takes a special kind of personality maybe I think to really go into somebody’s home, make them feel comfortable, make the family feel comfortable and themselves feel comfortable in that environment, to get to know somebody. That’s tough. Just, you know, being non-judgmental because you go into all different kinds of homes and trying to go into a home without having an air about you in any way. Just…I don’t know if I put that right -- just not being pretentious.

Consistent with the comments by their administrators, home visitors also mentioned that new home visitors needed to be very organized. This was described as a meta-skill that was needed for the home visitor to be able to accomplish all the aspects of their job.

I mean… I think in our particular job, especially me as a contract worker, I think a lot of time management skills is really huge because you are trying to manage this caseload and a schedule and a ton of paperwork and a lot of deadlines. So really, kind of time management and organizational skills, besides the relationship part of it. Really if you don’t have some of that, you’re not gonna…it’s not going to work out.

Finally, the home visitors felt that someone new to the field would need to adjust their expectations to recognize that client change happens slowly and in small ways. A theme mentioned from the Nurse Family Partnership training is “only a small change is necessary.” Other home visitors expressed this concept but used the term patience. In a parallel process, they recommended new home visitors be patient with themselves as they learned home visiting.

Patience is definitely a virtue around here. There is quite a bit of different areas we touch base on and not to get overwhelmed. We have the paperwork, understanding that we use several different programs, several different curricula, all in one, several different screenings. There’s so much training.
And,

A new home visitor… that it is going to take a little while to figure out how to be good at it. I kind of feel bad for the first clients that people get because they are not really getting what they could if they had an experienced home visitor. It’s going to take awhile to learn how to be a good home visitor. And you have to enjoy interaction. I think some people just want to be left alone when they go to work. And that’s what they are used to in other jobs. This is not the kind of job where you can just be left alone. You have to be ready everyday to have intense interactions with people who need stuff from you.

Situational Vignettes

Five situational vignettes were presented to the participants. The home visitors then responded as to how they might handle each of these situations in the field. The vignettes were written to elicit concrete examples of the home visitor’s work with families.

_scenario 1: You arrive for a visit with a client you have been seeing for 3 months.
She excitedly gives you an invitation to her baby’s Christening and asks if you can come.
Assuming you are free that date, what would you say?

Only one home visitor said that she attends the client events to which she is invited. These are mostly showers and weddings where she pops in for 30 minutes and gives gifts that are free to her from her place of employment (Linus blanket donations, Healthwise books, or baby thermometers). Another said she no longer attends but used to do so.

I started out going to all my clients’ showers, babies’ birthday parties, etc. only to find I personally could not keep up with it--time-wise and financially. And I had no time left for my personal life spending all my
weekends doing that so lately I have had “other plans,” “out of town,” etc., although I usually still give a gift.

The rest all stated that attending client family gatherings is against agency policy. Although there are times they wish they could attend a special event, overall they are glad to have this policy on which to fall back. A typical example of how this is explained to the clients included:

My agency does not allow me to attend family events. But know I’ll be thinking about you and baby. Thank you for thinking to include me in this special event and I’ll be looking forward to hearing about how it went and seeing pictures.

Home visitors noted that there are simply too many events to which they are invited. This seems a testament in and of itself to the impact they have on their clients’ lives. Home visitors also noted that it is not easy to tell their clients that they cannot attend. “I have been in this woman’s home every week for a year and I have to say no….I am not sure it is the best policy. I see some of my moms more than I see my best friends.”

Scenario 2: You arrive at a visit with a client you have only been seeing for about a month. She is frantically cleaning up for an inspection from the housing authority in 20 minutes. She is busy tidying and is worried that she won’t have time to clean the oven and stovetop (covered with old food spills). She tells you she knows the housing authority has been using this to evict people lately. Do you help her? Why or why not? What words do you use?

Only one home visitor said that she would clean with the client. “I would help her clean off the stove right there and then. Then I would work on a way to keep it that way; happens all the time. I’d just clean.”
All the rest of the home visitors said that they would not actually clean but would offer to help with the baby while the mom cleaned or offer to come back at a better time. They also said this is not a situation they had encountered although this researcher had. This particular scenario was based on situations occurring in public housing in Butler County, OH but apparently was not as common in other counties. Since home visitors in Butler County were not part of the sample due to the researcher’s personal experiences administering the home visitation program in that area, the scenario was more hypothetical for this sample.

Scenario 3: On your last three visits your client has had emergency crises that have taken up the whole visit. Today when you arrive, she tells you that she is going to be evicted today and has nowhere to stay tonight. Describe how the visit might go.

The home visitors were split in their response to this scenario. Unlike the cleaning scenario, all home visitors had experienced this scenario repeatedly. In fact, this scenario was developed due to the constant crisis in which many clients of these programs find themselves. With such clients, home visitors cannot wait to resolve the crises before working on the parent’s interaction with their child. Numerous crises may go on for the full two years they are in the program. This scenario was used to discover how excellent home visitors handle this conflict.

Half of the home visitors said they would need to deal with this crisis first. “If she doesn’t know where to stay tonight, that is very serious.” The home visitors had a routine they followed with their clients who were facing eviction depending on the services available in their area. For example, one home visitor broke this process into four seemingly routine steps.
1. I would ask what her plans are;

2. Suggest if no plan, calling homeless shelter for moms and children;

3. If no opening, call local churches to see if they could help pay for motel till space is available at shelter;

4. No responses from 2 or 3, I would call CPS (child protective services) with mom to seek help with lodging.

This half of the group of home visitors felt that addressing the crisis first was the better approach. “I would listen to her. She won't hear until I listen to her and she gets it out.” “Vent and then they are ready the next visit. Let them get it out at the front end.” These home visitors recognized that they would not get to curriculum on that visit but felt this decision was justified. “I hope the three visits before I would have gotten in some curriculum because they weren’t as serious of a crisis.” “I’ve actually found that when I respect the crisis, the next time we are able to do an activity and do what we need to do with the baby.” They also mentioned that they hoped that even when they were not directly using curriculum to teach the parents, they were always modeling interacting with their child throughout the visit. “I’m still modeling with the baby amidst conversation (or) point out something the baby is doing.”

Surprisingly, the other half of the home visitors said the visit would go on as planned. “Sometimes you have to go on and do the curriculum anyway or you would never get anywhere with those in chronic crisis.” Or “I get to at least a handout at every visit even if I don’t get to the activity. We discuss it even if there is a crisis.” Even if they have to improvise the curriculum, they noted that “Some clients thrive on crisis” so this scenario comes up a lot.
Scenario 4: One of your clients is a single mom on welfare with a new baby. While discussing her goals, she tells you what she really wants to do more than anything is to stay home and raise her baby and she would like to make her goal to find a way to do this.  How do you respond?

Only two home visitors stated that they would explain to the mother the impracticality of this goal even though they all recognized how difficult this goal would be for the mothers with which they work.

I would tell her that I would’ve loved to be a stay-at-home mom also but that realistically I knew I couldn’t.  I had a daughter to support.  So then I would try to focus on how I and how she might be able to be both the great involved mom she wants to be yet still be able to work, support her child, and achieve her goals.

The other stated that she would explain how TANF and OWF work and that many of her moms feel that they too cannot leave their child so become child care providers in their home.

The rest of the home visitors said they would strictly focus on the goal as given by the mother because “it is her goal.”  Some would even acknowledge that this goal can be seen as a positive by telling her "that's great” and “I think that it is great that it is your value to mother.”  The home visitors recognized the dilemma this scenario put them in. On one hand, self-sufficiency is a goal of the home visitation programs, namely as a result of funding that originally flowed from excess TANF dollars.  On the other hand, the attachment they have been working to see between mom and baby would quite possibly result in mom being unable to bear being away from their child in order to go to work to support the baby.  One home visitor stated, “they all want to stay home (and) it would be great if they could.”
Scenario 5: A mom you have been working with has unexpectedly not been at home for your last three visits. Today she is at home when you arrive. What, if anything, would you say about the missed visits? Why would you say that?

The majority of the home visitors said they would casually address the lack of participation on a friendly level being positive and pleasant. For example, “I was worried. Has everything been OK? Have you been busy?” or “Hey, gosh I really missed you the last three times. Anything I can help you with?” They would then try to make sure that this was not the mother’s way of refusing the program without actually saying so by asking her if she wants another home visitor or is not happy with the program. “(I would) ask how she feels about the program and if it is meeting her needs.” They may also remind the mother that “for our program to be successful it’s very important for us to have regular visits and tell her I could work around her schedule or whatever it took.” The attitude of the home visitors was not to take missed visits too seriously or as any sort of personal rejection. Some mentioned that they rarely have to ask moms about missed visits because “usually as soon as they hear my voice they are like ‘Oh my gosh. I’m so sorry’.”

Many mentioned specific procedures they have developed in order to reduce the problem of missed visits. These included confirming with the mothers a week before and not leaving for a home visit until they had spoken with the mom. Many encouraged moms to cancel the visits ahead of time by asking her to call and cancel an appointment if she cannot keep it so someone else could possibly schedule at that time. Another explained her process as:
When a parent misses a visit, I tape a notecard to their door with a short “sorry I missed you today” line, my phone number and signed with my first name. Usually, all I say when beginning the next visit is “I’m sorry that we missed visiting.” The parents then give an explanation voluntarily. I say it because I truly missed visiting the family. They have already heard me explain in the introductory home visit that I prefer visiting families over being in the office. And, I think they have seen in prior visits, my enjoyment of the visits (and) the activities with their child.

None of the home visitors said they would explain to mom the financial ramifications of missed visits on the program. Most programs do not get paid for missed visits and some home visitors are not compensated for them either. “I don’t think they know that I don’t get paid if they are not there. I think they would feel bad so I would never tell them.”

**Personality Scales**

*The Balanced Emotional Empathy Scale*

All respondents took the BEES at the time of their interview. Norms are available for comparison with this measure of empathy. Since all respondents were female, the z scores for females were used. Z scores ranged from -.48 (slightly low) to 2.29 (very extremely high) with an average of .75 and a median of .60, both of which would be considered “slightly high.” The researcher suspected that the excellent home visitors would be higher in empathy than the general population norms but this did not appear to be the case.
Myers-Briggs Type Indicator

The second test completed by all respondents was the Myers Briggs Type Indicator. The home visitors were equally divided along the polar ends of the four personality types. No attitudes or functions dominated the results. On the first scale, six home visitors were introverts and four were extraverts. Of the functions, five preferred sensing and five preferred intuition. Six home visitors preferred thinking and four preferred feeling. Finally, four home visitors had developed a judging type while six were a perceiving type. These results are shown in Table 3. The researcher suspected that since participants were all excelling in home visiting, they would be of similar personality type but this was not the case (See Table 4).
Table 4: The Four Preferences of the MBTI

<table>
<thead>
<tr>
<th>The Four Preferences of the MBTI</th>
<th>Index Pole</th>
<th>Number of Home Visitors</th>
<th>Index Pole</th>
<th>Number of Home Visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attitudes (EI)</td>
<td>Extraversion</td>
<td>4</td>
<td>Introversion</td>
<td>6</td>
</tr>
<tr>
<td>2. Processes of Perception (SN)</td>
<td>Sensing</td>
<td>5</td>
<td>Intuition</td>
<td>5</td>
</tr>
<tr>
<td>3. Processes of Judgment (TF)</td>
<td>Thinking</td>
<td>6</td>
<td>Feeling</td>
<td>4</td>
</tr>
<tr>
<td>4. The Style of Dealing with the Outside World (JP)</td>
<td>Judgment</td>
<td>4</td>
<td>Perception</td>
<td>6</td>
</tr>
</tbody>
</table>

Data Extension

As presented thus far, the beginning codes offered a description of the data. Interviews had continued until no new information was gleaned from the interview questions beyond what was presented in the previous data reduction section. However, further interpretation of the data was needed for meaning.

When asked what the home visitors thought made them good at their job the resulting codes were non-judgmental attitude, their approach to families, and ability to form relationships with clients. These beginning codes were consistent with the existing literature which also proposed that the relationship between home visitor and client was “at the heart of the home visiting process” (Wasik, 1993, p. 140). However, it is also important to recall that Olds and Marchi (2002) have stated: “while we know, in general, that the helping relationship is important in infant/family work, we still have much to learn about the details” (p. 21). Further interpretation involved the process of moving from descriptive to inferential coding (Miles & Huberman, 1994). Understanding the
characteristics of home visitors perceived as excellent by their administrators was a process where the analysis flowed from the data and additional literature was concurrently explored.

Bridging Codes

The researcher was immediately struck by the likeness of the home visitors interviewed but struggled to meaningfully describe their similarities. In order to continue coding the data for inferential meaning, bridging codes were used to produce and organize relationships between similar codes (Miles & Huberman, 1994). Initially, beginning codes were organized into three categories: (a) attitudes, (b) skills, and (c) knowledge.

This became problematic as it was often difficult to place some codes clearly in one category over another. It appeared that attitude, skills, and knowledge were not orthogonal categories. Similarly, home visitors had a difficult time when asked three separate questions regarding what they felt new home visitors should possess regarding attitude, skills, and knowledge. Nonetheless, the home visitors clearly expressed that they felt their attitudes were key. Home visitors felt that clients let them into their homes because of their accepting and positive attitude. They made comments including “You don’t want to go in with a negative mind because then the moms will just think that their situations are negative,” and I “try to look at the good,” and “there’s good and positive in even the worst of situations.”

In an effort to describe the attitude of home visitors perceived as excellent, the “attitude” category was extended (Lincoln & Guba, 1985). Extension involves “returning
to materials coded earlier and interrogating them in a new way with a new theme, construct, or relationship” (Miles & Huberman, 1994, p. 62). Any data related to the attitude of home visitors was placed in one of three categories: (a) attitudes towards clients, (b) personal attitudes, and, (c) societal attitudes. This framework was adapted from a guide to learning and training for pediatricians (Royal Australian College of Physicians, 2001) and produced the following themes:

1. Home visitor attitudes towards clients:
   a. Enjoy children
   b. Non-judgmental
   c. Flexible
   d. Client-focused
   e. Empathic
   f. Respectful (approaches the client as if the home visitor is a guest in their home)

2. Overall personal attitudes of home visitors
   a. Enjoy fieldwork
   b. Positive attitude
   c. Respect for personal differences, diversity, culture, opportunities
   d. Non-judgmental attitude towards people’s character, behavior, and beliefs
   e. Honest and compassionate
   f. Flexible
   g. Having the habit and principle of lifelong commitment to improvement

3. Home visitor attitudes toward society
a. Believe people can change

b. Believe home visitation can make a difference to society

The above framework still possessed overlapping themes and did not appear to offer many impressive insights. Klass (1996) offers a possible explanation as to why this particular extension did not prove as fruitful as hoped. She states, “home visitors’ actions arise from an interaction of their personal abilities, style, and experience” (Klass, 1996, p. 93). Attitudes, skills, and knowledge are overlapping and interdependent which explains the difficulty of the researcher and participants in meaningfully using these categories. An attitudes, skills, and knowledge framework proved complicated and of limited use in describing the characteristics of exemplary home visitors.

**Filling In**

A reconstruction of the data was needed. “Reconstructing a coherent scheme as new insights emerge and new ways of looking at the data set emerge” is the process known as “filling in” (Miles & Huberman, 1994, p. 62). The attitude-based framework was deconstructed and the individual codes were explored in the literature for direction and insight. These codes led to three broad areas of research and practice literature on: (a) therapeutic relationships, (b) the Nursing Model of Caring, and, (c) strengths-based practice. Filling in the codes with information found in the literature resulted in some of the codes merging into coherent themes and taking prominence over others.

The overlapping codes began to reveal meaningful insights with the assistance of the literature. Several codes were found to be actually representative of one theme. For example, some of the codes previously placed within the category of home visitor
attitudes towards clients: (Non-judgmental, Empathic, and Respectful) as well as codes from the overall personal attitudes of home visitors category (Respect for personal differences, diversity, culture, opportunities, Non-judgmental attitude towards people’s character, behavior, and beliefs, and Honest and compassionate) were all found in the literature on therapeutic relationships. In fact, it was discovered that the concept of empathy actually includes the three components of honesty, lack of judgmental attitude, and respect for the client. Furthermore, the self-awareness necessary for the development and expression of empathy from helper to client became a second theme. From the personal attributes of home visitors the code “Having the habit and principle of lifelong commitment to improvement” was found in the literature on strength-based practice and was re-named “lifelong learning.”

The codes of Client-focused, Positive attitude, and both codes in attitudes towards society category (Believing people can change, Believe home visitation can make a difference to society) lead to literature on the Nursing Model of Caring and strength-based practice. The new reconstruction found these codes to be reflective of a belief in change by focusing on strengths and merged into “belief in change.”

Reconstruction of the data resulted in five characteristics that best described the home visitors believed to be excellent in a meaningful, original, and useful way:

1. Effective at forming and maintaining empathic, therapeutic relationships
2. Self-awareness
3. Lifelong learner
4. Belief in change
5. An ecological approach to working with clients
The above five traits offered a useful and unique description of the personal attitudes of the excellent home visitors interviewed and will be explored and illustrated in detail.

**Relationships**

The importance of relationships was oft-discussed by the home visitors. When asked the key to their success, home visitors replied with comments such as “definitely a connection with the mom.” Home visitors focused on their relationships with clients and the importance of that relationship as demonstrated in their comments.

This job is a lot about relationships and I’m not going to be able to get in the home and give out parenting information and developmental information if I am not able to have a relationship with this woman and she doesn’t want me there.

And:

So if they don’t want me to be there, then they just aren’t there. It is a voluntary program. It’s free. They can just tell me to go away if they want to and I say ‘OK. Goodbye.’ So it really…if that relationship’s not there, it’s not going to work.

The home visitors’ assertion that the relationships they form with their clients allows them to make a difference is supported in the literature. “The relationship is, in and of itself, therapeutic” (Welch, 2005, p. 161). Although home visitors do their work in the client’s home rather than an office, one of their roles is counseling. The relationship between therapist and client has been found to be a primary curative component (Lambert & Barley, 2001). The helper’s interpersonal style is key in the forming of therapeutic relationships (Parloff, 1956). Parloff (1956) compared the perceived relationship between patients and two different psychotherapists. The quality
of the relationship between the psychotherapists and patients was rated both by the
patients and external judges. The psychotherapist that scored higher with his patients was
also rated as having better social relationships by their own associates. Hence, the same
doctor who formed better social relationships also was judged to form better therapeutic
relationships (Parloff, 1956). Quality of relationship may be a function of the visitor’s
personality as a good therapeutic relationship is very much like any good relationship
(Fiedler, 1950; Winstead, Derlega, & Lewis, 1988). Long recognized as an important
skill in helping professions, forming relationships is easier for some than others.

The outstanding home visitors recognized that they were skilled in forming
relationships with their clients even if they were not sure how they did so as illustrated in
these quotes.

But I knew that I loved the relationship part so I thought since this was a
job really based on that, it would be like the job for me. And that part in
life for some reason is just something that…I’m not trying to ring my own
bell or anything…but just something that I tend to be good at. It tends to
be easier for me than some people. Some people have a harder time
forming relationships. I seem to be able to do that quickly and that’s just
something that I’m tuned into or something and so it just works for me.
So I don’t know exactly how I seem to be able to do it; to connect, but it
just seems to work and I wish I could tell you what exactly what makes
that happen but I do seem to be able to do the relationship forming part of
it.

And,

There is no magic way to build relationships with people but good training
on how to develop relationships with people. But, you know, at the same
time I don’t know if there is a training for that. Sometimes I feel like
that’s almost who you are if you are able to really do that with families. I
don’t know. It takes a special kind of personality, maybe, I think to really
go into somebody’s home, make them feel comfortable, make the family
feel comfortable, and themselves feel comfortable in that environment. To
get to know somebody. That’s tough.
The therapeutic relationship is dependent not only upon the therapist’s interpersonal style but also on facilitative conditions. Facilitative conditions include empathy, warmth, and congruence (Lambert & Barley, 2001). This trio is essentially the same as what Carl Rogers called empathy, positive regard, and genuineness (Rogers, 1951). The three factors: (a) therapeutic relationship; (b) therapist’s interpersonal style; and, (c) facilitative conditions are called common factors. The importance of common factors has been well-researched (Hubble, Duncan, & Miller, 1999).

Lambert and Barley (2001) performed a meta-analysis on over 100 studies examining the contributing factors to client outcomes in therapy. They concluded that “decades of research consistently demonstrate that relationship factors correlate more highly with client outcome than do specialized treatment techniques” (p. 359). Common factors accounted for 30% of change while extratherapeutic factors (40%), expectancy effects (15%), and specific therapy techniques (15%) accounted for the difference (Lambert & Barley, 2001). Similarly, De Shazer and Berg (1997) report “all therapy models work and many clients report that they benefited simply from talking to a therapist” (p. 122).

Common factors include the three interrelated aspects of therapist variables, facilitative conditions, and the therapeutic relationship (Lambert & Barley, 2001). It is important to note that these three aspects of common factors are not mutually exclusive, but rather overlapping and interdependent (Lambert & Barley, 2001). Nonetheless, the better the relationship with the client, the greater the possibility the client will benefit (Parloff, 1956). Social work has also recognized the role of facilitative conditions. The personal qualities of empathy, positive regard, and genuineness are seen as important to
the relationship between client and social worker (Hepworth, Rooney, Rooney, Strom-Gottfried, & Larson, 2006).

Empathy is repeatedly mentioned in the literature on therapeutic relationships (Fiedler, 1950; Gelso & Carter, 1985; Lambert & Barley, 2001; Winstead et al., 1988). Oft-associated with the work of Carl Rogers, the term empathy as defined by Rogers (1951) included affective, cognitive, and communicative components. The affective component reflects the professional’s sensitivity to the client’s feelings (Rogers, 1951).

The cognitive component involves the professional’s observation and mental processing of the client’s experiences (Rogers, 1951). The communicative component encompasses the helper’s response (Rogers, 1951). Hence, the helper has to observe the client’s emotions, be sensitive to their feelings, and then communicate their empathic feelings to the client. Rogers (1951) provided the following description:

It is the counselor’s function to assume, in so far as she is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he/she is seen by himself, to lay aside all the perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding of the client (p. 348).

Empathy is recognized as an essential element in the construction of the relationship between social worker and client (Freedberg, 2007). “Current social work literature generally concurs that empathy calls for the practitioner to understand the client’s feelings and circumstances as well the meaning the client attributes to his or her sense of reality” (Freedberg, 2007, p. 253). Empathic responses demonstrate that the social worker is attending to the client’s emotions (Hepworth et al., 2006). “Failure to empathize with clients leads to the client’s premature withdrawal” (Freedberg, 2007, p. 253).
Hence, social work has long recognized empathy as a critical element in helping relationships (Freedberg, 2007).

Since the 1950s, the term empathy has been widely used “amid much confusion” (Wiseman, 1995, p. 1162). Wiseman (1995) provided a concept analysis of empathy in which she concluded there are four defining attributes: (a) see the world as others see it; (b) understand another’s current feelings; (c) nonjudgmental; and, (d) communicate the understanding. The confusion around empathy includes disagreement as to whether empathy is a state or personal trait of the helper. Unfortunately, Wiseman could not conclude empathy to be dynamic or a static trait. Rather, she concluded that “a person must have a disposition to be empathic (trait) but whether she/he is depends on a number of factors (state)” (Wiseman, 1995, p. 1166). This concurs with the theory that empathy is not present or missing but rather empathic responses happen on a continuum from not empathic to very empathic (Hepworth et al., 2006).

Each outstanding home visitor completed a measure of empathy called the Balanced Emotional Empathy Score (BEES). Given the importance of empathy in the literature and that these were excellent home visitors; one could expect that these home visitors would all score quite high on this measure. In comparison to norms, this was not the case. The home visitors’ scores on the BEES as compared to the normal continuum can be seen in Figure 1. Two home visitors scored more than two standard deviations above the norm which rates them as “very extremely high” in empathy, but another scored below the norm or “slightly low.” Most home visitors (seven) scored within the range of “average” to “moderately high” in empathy. This seems to indicate that unusually high empathy was not found in these excellent home visitors.
If the literature is correct and empathy is a key factor in building relationships with clients, why did these outstanding home visitors who recognize the importance of empathy and building relationships with their clients, not display higher scores? This researcher believes the answer lies in the interaction of the continuum theory of empathy and the self-awareness needed for improving empathic skills. Given that empathic responses can be enhanced through self-awareness, unusual empathy is not needed. Rather “good enough empathy” is needed. This group of excellent home visitors was not uniformly more empathic than other females but none were very low in empathy. Home visitors need to have “good enough empathy” meaning that they are at least normal or above normal in general empathy but skilled in showing empathy to their clients.
By combining the above literature on helping relationships and common factors, the first conclusion was reached: excellent home visitors are good at forming relationships and the variables that facilitate formation of relationships in home visitors include the facilitative conditions of: (a) congruence, (b) positive regard, and, (c) “good enough empathy.”

The first facilitative condition is congruence. “Genuineness or congruence refers to the therapists capacity to be ‘real’ in the relationship” (Gelso & Carter, 1985, p. 213). Home visitors cannot rotely form relationships with clients. Nor can they pretend to care about their clients and their children. They must truly believe in their client’s work as mothers and their own ability to impact it. In this way, they are authentic. Authenticity is the “completeness and seamlessness in the manner in which they were able to meld their selves into a professional persona with little or no conflict of interest, dissonance, distance, or reserve” (Welch, 2005, p. 164). Home visitors recognized that they had to be truly accepting of their clients because if not, that lack of acceptance would eventually become visible to the client.

I think that the most important thing would be to accept them where they are- the home visitor accepting the family where they are. And that you have to be careful about verbals as well as non-verbals in showing that acceptance. Their lack of furniture shouldn’t prevent you from sitting on the floor and playing with their children. The smells and odors in the home shouldn’t prevent you from speaking to them as you would somebody else who had a home and garden home.

The second, positive regard, is genuine care for the client such that any “behavior that is overtly or covertly judgmental or evaluative is avoided” (Gelso & Carter, 1985, p. 213). Home visitors recognized their lack of judgmental reactions as a key to their success.
I would say that when I came into it, it was my open mind and my non-judgmental...like I had a social work teacher that would tell me ‘I could tell you that I murdered somebody and you just wouldn’t react to me. Another home visitor stated that she warns new home visitors that they are probably going to see a lot of things that are going to make them uncomfortable and that they can’t put their judgment and background “on” to judge the client. “Sometimes I say to myself ‘well, if they can live there, then I can visit.”

The relationship between helper and parent is enhanced when the helper assumes the parent wants to do well by their child and is the expert on their child (Brazelton, 1992). This appears to be the case in the outstanding home visitors as they made comments including “the parent is the authority about their particular child.” In respecting the client’s decision, the home visitor must relinquish control to the client.

Rapp (1996) describes this concept as venerating the clients. If the home visitor truly respects the client they must also accept the decisions they make. The outstanding home visitors discussed their respect for the decisions made by their clients.

Interviewer (clarifying): It goes back to kind of that non-judgmental… Home visitor: Yes! Yea… just being the presenter of information and not trying to project my own beliefs and values on parenting and things like that. Just being like, with the information, this is the newest information on brain research and it is up to you, you are the parent, to decide what’s bet. Just try not to really put my own beliefs in there.

Hence, positive regard can be expressed in home visiting by showing respect to the families and recognizing that the parent is the expert on their child demonstrated in the following quote:

Not reacting or judging them. Not to judge them. You know, it’s their journey. It’s kind of maybe a way I approach them as well. This is their life, their journey and they can make the choices that they want and I just help support them to make those choices. They are not the choices that I
would pick for myself or that I was probably hoping they would pick for them but then after they make that choice I just have to get on board. I can’t always be like “well, you know, this was your decision.” I just have to support whatever they decide.

The following quote illustrates how one home visitor expressed both her genuineness and positive regard for her clients.

I think they can feel if you are judging them; if you are disapproving of them or if you just kind of very accepting of them and wowed by them. Wowed by what they have done and you think that they are a good mother and you are excited for them to be a mother.

Thirdly, home visitors need to possess “good enough empathy” meaning that they need not be extraordinarily empathic but at least averagely so. Home visitors recognized their empathic skills.

It’s not just hearing what people are saying – it’s knowing and understanding and being able...sometimes with the new moms it’s not that they need someone to come in and solve their problems or tell them how to be a good mom. It’s listening to what’s going on in their life just so they can get it off their chest.

The concept of “good enough empathy” is compatible with both the trait and state theories of empathy. As a trait, “good enough empathy” indicates that home visitors must have a disposition to be empathic, although not unusually so. As a state, “good enough empathy” is found along a continuum. The continuum approach opens the door for successful training on the communication of empathy or improving the home visitor’s expressive state of empathy.
Self-Awareness

Several researchers believe they have proven that expressions of empathy can be enhanced (Lambert & Barley, 2001; Stepian & Baernstein, 2006; Winstead et al., 1988). Stepian and Baernstein (2006) found in their review of the literature that brief and targeted interventions could have major and lasting impacts on the practitioners’ ability to display empathy. Lambert and Barley (2001) reported that successful training on the communication of empathy can be accomplished by adapting the professional’s response style to clients. Although some people may be considered naturally empathic, natural empathy can be enhanced through improved listening skills; however, self-awareness is needed as a prerequisite to this effort (Wiseman, 1995). Freedburg (2007) states that the following traits are necessary for appropriate empathy:

- the capacity for emotional connection with others, the worker’s ability to be in touch with his or her own feelings and thoughts in the moment as they arise in direct response to the client’s affective and cognitive state, and flexible self boundaries that allow the affective flow necessary for empathic connection (p.255).

Thus, in order for the worker to experience genuine empathy, they must allow him or herself to be vulnerable and moved by another, be truly engaged in the moment, and in touch with their own feelings. Hence, the trait of empathy is expressed in empathic states but empathic states are enhanced by the trait of self-awareness. Freedburg (2007) concludes that genuine empathy is best found and enhanced in persons who are mature, self-aware, and have a clear sense of self. Skilled social workers can also become acutely self-aware through professional training (Freedberg, 2007).

The concept of “good enough empathy” and the research on improved expression of empathy lead the researcher to a second conclusion. Self-awareness is an important
trait for home visitors. Self-awareness, as defined here, requires the home visitor to be in touch with his or her own feelings and thoughts during visits while attending to the clients’ affective and cognitive state.

Self-awareness is a prerequisite for improving one’s empathic skills. Self-awareness is a necessary personal trait for empathic responses to clients (Freedberg, 2007; Lambert & Barley, 2001; Wiseman, 1995). Self-awareness allows for reflective practice and the forming and maintaining of better client relationships. One home visitor stated “to establish that rapport- I think the experience definitely helps that to be established quicker than it used to.”

Home visitors expressed their ability to be self-aware by recognizing their own strengths and weaknesses. For example, one home visitor stated “I have boundary issues.” This home visitor recognized this about herself and described the on-going process of evaluating her own actions in the field with respect to boundaries. She gave an example where she and her supervisor agreed her crossing of typical nursing boundaries was appropriate in the particular situation after the home visitor assisted one of her clients in the delivery room.

I got to focus just totally on labor support for her. And so when this baby was born I was real excited and I said “I just felt like I was watching my grandchild be born or something.” And when I say that kind of stuff my supervisor just cringes. Oh my god. I told her “I know you hate when I talk that way and stuff but the same thing that you think is my boundary issue, to me is also the same thing that makes me a good nurse home visitor in my estimation because that is why I do form the relationships with them and they do connect with me is that they do know that I truly care.” Maybe I care too much and that’s the double edged sword part of it but I think that that’s the part that makes it work.
Additional statements demonstrated the home visitors’ awareness of the role their own history played in their work. “Being a young mom, I identify with a lot of younger moms.” “You start a job like this and you realize how great the family you came from was” and,

I’m pretty compassionate in the fact that I know that I was raised pretty good. So I come from a background of people nurturing me and having discipline and being raised right. And a lot of the families that I work with, they come from domestic violence in their past or abuse in their past so I know that cycles repeat. So for me I’m trying to stop that cycle. Not necessarily judging them for having lived that life.

Home visitors expressed awareness of their internal stress and ability to cope with it. “We have our nice little personal days and sick days if it’s really, really overwhelming and we need a break.” “I meditate in the mornings if I am overwhelmed for the day.”

Additional quotes demonstrating home visitor self-awareness in practice include “I enjoy the face to face contact with the parents…I like the vitality or the intrinsic reward of seeing these families and learning about their children. And it’s an age that I particularly enjoy.” And,

I just graduated one and I don’t like where she’s at now. I would have hoped things to be different but that’s where she is and I think that she thinks that I helped her. I struggle with that, too. But I just have to remind myself a lot that these are their lives; their journey. Therefore, I’m just someone to help them along the way.

I would say that that’s something that, over many, many years, I’ve kind of come together with. I’m sort of that kind of person just in real life. I’m not a “tell people what to do” kind of a person. But, you know, just sort of reading people and kind of reading different types of personalities and knowing sort of, what’s the best way that I am going to get across my point to that personality and that kind of person? You know, not that I’m not a direct person, but you know you got to put a little cushion on it to get across to some of these 16 year old mothers.
Although self-awareness appears a critical trait of outstanding home visitors, it is not necessarily that they have an introverted personality. Introversion is the “attitude that orients attention and energy to the inner world” (Myers & McCaulley, 1985, p. 224). All home visitors completed the Myers Briggs Type Indicator which includes the introversion/extraversion scale. Home visitors were equally divided along the polar ends of all four personality scales. On the first scale, introversion/extraversion, six home visitors were predominantly introverted and four were extraverted. This almost even division indicates that both introverted and extraverted types make excellent home visitors. Home visitors do not necessarily have to be introverted to be self-aware, but it is likely that those with extraverted personalities recognize that they need to compensate for their natural tendency and focus on their inner world to improve their practice. In other words, these excellent home visitors may balance their personality type by recognizing their own strengths and weaknesses and then compensating for the aspects of personality that come less easily to them. This maturity may result in home visitors’ ability to understand their natural tendencies and compensate to be for example, both introverted and extraverted as appropriate.

Maturity has been found to assist the development of self-awareness (Freedberg, 2007). Home visitors mentioned maturity as key to their success; however, it is important to note that maturity in the case of home visitors does not require any specific age as the excellent home visitors spanned all adult age groups.
Life-Long Learning

These home visitors that were excellent at forming relationships with their clients were also easy to interview and seemed to put the researcher quickly at ease as well. As previously mentioned, this researcher was struck by what was perceived as a humble approach towards their work.

Even though the home visitors were especially good at working with their clients, they did not credit their client’s success to themselves. For example, one home visitor stated: “I don’t go in with any type of ‘I’m the authority’ on anything. I’ve had good luck with kind of going in saying ‘here’s some information that I have. I’d like to share it with you.’” Another stated, “you are going into someone else’s home and you need to…build rapport with that person. You need to not go in there trying to be the expert and the all-knowing. It really is about relationships.” The outstanding home visitors seemed to recognize that a ”hierarchal relationship is likely to alienate the client” (Lee, 2003, p. 389). As another visitor expressed it:

They are not respected, I guess, by society but they are respected as an equal to me. I mean they are my equals and I don’t care their age…You are my equal. You’re a mom. I’m a mom. I’m here and we’re equals. I treat you with respect. You treat me with respect.”

What initially appeared to this practitioner as a humble attitude can be better explained as empowering practice. By interacting with clients in ways that reduce their role as expert and direct the clients to their own goals, the home visitors are actually empowering clients. While home visitors may describe themselves as sitting back and sharing information as needed, they are actually demonstrating the complicated skill of empowering clients.
Just as the relationship between home visitor and client can be in and of itself, therapeutic, so can empowering practices. Empowering mothers is consistent with feminist standpoint theory (Swigonski, 1994). Empowering new mothers requires patience and practice. One participant explained that “it’s going to take awhile to learn how to be a good home visitor.” Constant improvement requires a positive attitude towards learning new skills. Several mentioned their positive view towards the formal education system such as “I think I’d like to get more education,” “I like school,” “I think I’d like to get more education…I think there’s more out there. I don’t know if I’ve come across it yet,” “I should get my master’s” and “I would like to go back to school.” One home visitor demonstrated her positive attitude towards adult learning by going “back to college when I turned 50.”

The researcher had required that each home visitor to be interviewed have worked in the field for at least one year allowing the completion of core training. The initial training in home visitation is lengthy and often takes a full year to schedule and complete. As one visitor stated, “there’s so much training!” For example, when asked “do you have any other specialized training you feel it is important to mention?” a home visitor responded:

With the Nurse Family Partnership we go out… we went to Colorado. Well, we went several places for like a three-part training and then there’s Family Partnership in the Olds Program. We trained in that. We have the NCAST certification for NCAST Teaching and Feeding.

Interviewing seasoned home visitors allowed for a knowledge base across all the visitors. The knowledge required for home visiting is not that complicated but requires patience and a positive attitude during the long training process. Converting knowledge
into practice is far more challenging. The necessary skills can be taught within reflective practice as long as the home visitor is open to continuing to learn and improve their skills. Although empathy, positive regard, and congruence can be enhanced, Klass (1996) claims that they can only be learned through a long process of reflective practice. Reflective practice for home visitors requires a spirit of inquiry in which the visitors think about their own experiences while integrating new information (Klass, 1996). Participant comments demonstrating their spirit of inquiry included “I enjoy learning from them (parents)” or “To ever increase my knowledge about those particular ages and brain development,” “And you keep plugging along to figure out what’s the way to reach that particular person.”

The third conclusion reached by this researcher is that home visitors need the attitude of a life-long learner in order to reflect and improve their practice with families. The attitude of a life-long learner allows the home visitor to successfully integrate the long training process into their practice and to continually improve and expertly perform their work. Rapp (1996) describes this attitude as learning for a living (p. 168).

**Strengths**

As previously discussed, home visitors work with their clients within a therapeutic relationship. The role of therapeutic relationships has been long recognized in psychology and social work (Freedberg, 2007; Hepworth et al., 2006; Parloff, 1956). The field of nursing also recognizes the importance of the relationship between nurse and patient and several of the home visitors interviewed were trained as nurses. The Nursing Model of Caring describes the characteristics of nurses needed for therapeutic patient
relationships (Swanson, 1993). “Caring is a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson, 1991, p. 165). The Nursing Model of Caring is applicable to home visitors whether they be nurses, social workers, or from other backgrounds as “caring is not uniquely a nursing phenomenon” (Swanson, 1991, p. 165).

The Nursing Model of Caring includes: (a) Maintaining belief; (b) Knowing; (c) Being with; (d) Doing for; and, (e) Enabling (Swanson, 1993). “Maintaining belief” is the initial and essential component of a helping relationship. It includes “holding the other in esteem and believing in them” (Swanson, 1991, p. 165). In addition, “Maintaining belief” is necessary for the appropriate expression of the other four components of caring (Swanson, 1993). “Maintaining belief” is a positive philosophical attitude in general and toward the client specifically (Swanson, 1993). It is a “fundamental belief in persons and their capacity to make it through events” (Swanson, 1993, p. 354). One home visitor’s words seem to describe this concept:

You need to believe in what you are doing, obviously, or you just kind of go out there and spew information. I believe that children have the right to a happy family life and that mothers have the right to a happy family life and that that’s what’s really important and that you are helping that to happen. Then you feel good and want to do it if you believe in it. And that’s definitely what I believe in. Children and mothers have the right to wake up together and feel safe and cozy and warm and happy and have something to look forward to.

One home visitor mentioned “strengths- based training” in the 1980s as a key to her success leading her to believe her clients “want to be the best parent they can be.” Benner and Wrubel (1988) describe caring as “a profound act of hope” (p. 1075). Research into hope, healing, positive expectations, and possibilities provides some of the
base of what is also called the strengths perspective (Sousa, Ribeiro, & Rodrigues, 2006). The concept of “Maintaining belief” is similarly represented in the social work literature as the strengths-based approach.

Although often described by what it is not, strengths-based practice includes “a focus on client strengths and self-direction” (Brun & Rapp, 2001, p. 279). The underlying assumptions include beliefs that all people have abilities and resources and are capable of growth and change (Rapp, 1996). “To believe unstintingly in the strengths and potential of all families requires a leap of faith on the part of the professionals who work with families” (Weick & Saleeby, 1995, p. 147).

The fourth conclusion reached by the researcher was that home visitors must maintain a belief in the client’s ability to change and this is best accomplished by focusing on client strengths. A core attitude of believing in the client and their ability to change is necessary for congruence in the home visitor’s words and actions with the client. As one home visitor stated:

Some of my friends are like ‘how in the hell you can you do that job? I could never do that job.’ And to me, I know that they could never do my job either because they do have...they just can’t take themselves out of other people’s situations. Or like I’m pretty compassionate in the fact that I know that I was raised pretty good so I come from a background of people nurturing me and having discipline and being raised right. And a lot of the families that I work with, they come from domestic violence in their past or abuse in their past so I know that cycles repeat. So for me I’m trying to stop that cycle. Not necessarily judging them for having lived that life. I believe in change. Absolutely. And I’m a democrat.

Although home visitors, like most social workers, have received some training or education on the strengths-based approach, it cannot be assumed that they all actually truly embrace this view or are able to practice it. Traditional social work practice has
long struggled with the conflicted focus on both strengths and deficits (McMillen, Morris, & Sherraden, 2004). Sousa, Ribeiro, and Rodriques (2006) studied workers who served multi-problem poor clients much like those served in home visitation programs. They found that workers were unable to leave a problem-centered view behind and concluded that “the problem-centered perspective is dominant and that a shift in perspectives is still in an incipient stage” (Sousa et al., 2006, p. 189). When asked, workers could identify client strengths but did not appear to believe in them or rely on them to help the family. “Thus, practitioners assume the traditional role of expert” (Sousa et al., 2006, p. 200).

Assuming the role of expert is one of the signs that the helper has not actually embraced strengths-based practice. One home visitor recognized this and stated in regards to strengths-based work: “so you can’t just wink and nod. You better live it.” Empowering clients to build upon their unique strengths requires home visitors to work with those clients via collaboration and consensus. From a feminist standpoint, empowerment can only be accomplished via support and encouragement.

I think women are incredibly important. I do think that a lot of my moms are the primary caregivers of their babies and you know, being strong members of society. Being able to empower them to know what they can do and what’s out there for them and empower them to be able to be good parents and do everything else that they want to do too.

Rather than a working relationship based on the power of the home visitor, a therapeutic relationship where the contribution of the client is not only recognized, but valued, is utilized.

Hence, the home visitors recognized “the parent is the authority about their particular child.” “They are in the driver’s seat.” Klass (1996) suggests there is great benefit in not assuming the role of expert especially for new home visitors. “Learn to
trust your own judgment and intuition. As long as you maintain a respectful stance with the client, your incomplete information or lack of knowledge can be turned into an asset. For instance, by acknowledging your lack of information, you make the client the “expert” (Berg, 1994, p. 20). Another home visitor explained this as:

I always tell moms that I am the bearer of information and not coming in to tell you how to be a parent but really just to bring in the information and let (you) decide what’s best for (your) children.

Berg (1994) states the first task for the home visitor is “to start seeing the mother as a competent, effective person and to start looking for her strengths” (p. 62). The excellent home visitors expressed this notion in comments such as:

There are situations that aren’t the best. And there’s good and positive in even the worst of situations. If they’re telling their child that they are doing a good job or they are smiling about any kind of positive things….you try to point out something positive about their parenting each time.

Or, “I enjoy working with teenagers and encouraging them and their- what they don’t see as positives, I guess. Helping them see the positives and everything.” Berg (1994) warns to “always maintain a positive, hopeful view of clients and your work with them. When you are hopeful you tend to convey that to them in many subtle and nonverbal ways (p. 20). It was apparent that the home visitors genuinely believed in change but were able to recognize that the changes parents would make do not come about all at once. A saying used by the home visitors was “only a small change is necessary.” Additional quotes include “a belief that small steps are progress and I’m gonna be there hopefully for three years,” or:

a lot of times I may have a girl for three years and then she might come in after she’s graduated or I might see some change then, but it’s like we
don’t see a lot of immediate, drastic changes. We draw on little tiny strengths.

Home visitors saw power in tiny changes over time and used the metaphor of comparing their work with parents to water forming a cave over a long period of time. This has been called “the drip, drip, drip effect” in home visitor training and this metaphor was used by several home visitors.

If we can make this a better situation for that parent, well then that baby’s gonna be in a better place. And maybe then…we are not gonna break any cycles with the mom but maybe we can with that baby just by our education with the mom. What we are gonna do is hopefully through our relationship with her, show her a better way and there’s where the cycle is gonna be broken; with her baby.

“From a strengths-based perspective, the ability of the practitioners to motivate clients by expressing a positive regard for their competencies and capacities is powerful” (Sousa et al., 2006, p. 200). Without it, the relationship between practitioner and client suffers (Sousa et al., 2006). Hence, the home visitor’s ability to form and maintain relationships with their clients (conclusion one) is enhanced by their strengths-based practice (conclusion four).

Clearly, the home visitors believed in change as demonstrated by numerous quotes such as “I like being involved with the moms and parents hoping (or helping) to make a difference.” This belief in change includes themselves which makes them open to reflective supervision.

Home visitors must also focus on their own strengths which allows them to project that confidence in themselves and their ability to assist clients in changing. “Experienced home visitors are confident themselves. They trust the power of the
process of the developing relationship” (Klass, 1996, p. 14). They believe in their ability to empower their clients.

A strengths-based approach is client-driven. “We cannot deny the reality and possibility of any family’s aspirations. Rather we must learn to ride the crest of such hopes and visions with families” (Weick & Saleeby, 1995, p. 147). This was especially evident in the home visitors’ response to the following scenario:

*One of your clients is a single mom on welfare with a new baby. While discussing her goals, she tells you what she really wants to do more than anything is to stay home and raise her baby and she would like to make her goal to find a way to do this. How do you respond?*

None of the home visitors responded by dashing the mother’s hopes. Only two home visitors stated that they would even explain the impracticality of it. In fact, many noticed that such a goal might be an indication of their success in getting the mother to believe she was doing an important job well. The rest of the home visitors said they would strictly focus on the goal as given by the mother because “it is her goal.” Some would even acknowledge that this goal can be seen as a positive by telling her “that's great” and “I think that it is great that it is your value to mother.” The outstanding home visitors appeared to follow a strengths-based practice assumption by maintaining “a healthy disrespect for the impossible” (Rapp, 1996, p. 166).

*Ecological World view*

In order for a home visitor to assist parents in therapeutic change, they need an understanding of systems theory and the impact that the environment can or has had on those clients. Without an ecological approach, home visitors are likely to blame the
families with which they work for their unfortunate situations such as poverty. Klass (1996) warns “given our individualistic culture, it is not given that the average home visitor will take an ecological approach” (p. 96).

Social work has clearly focused on the interaction of the client and their environment (Hepworth et al., 2006). The ecological systems model has been used as the unifying framework for social work theory and practice (Hepworth et al., 2006). Hepworth and associates (2006) warn social work students that “a failure on your part to focus on family-environmental interactions may cause you to have an incomplete understanding of family functioning and hence to develop interactions that emphasize pathology over strengths” (p. 474).

Empowering clients is one way to illustrate this underlying belief. The research of Dempsey and Dunst (2004) supported the notion that a helpgiver’s personal style as well as professional training affected their client’s perceptions of empowerment. The clients of social workers felt the most empowered followed by the clients of nurses (Dempsey & Dunst, 2004). It appears likely that these two professions have incorporated ecological theory into training more than others. Social work focuses on the person in the environment (Hepworth et al., 2006). Nurses are told that they “must recognize the influence that internal (mental and spiritual well-being, and incorporated sociocultural beliefs) and external environments (societal attitudes, cultural expectations, religious doctrines, political climates, laws, social policies, and economics) have on the health status of individuals, families, and society” (Swanson & Wojnar, 2004, p. 45).

The excellent home visitors seemed to believe in the impact of the environment on their clients.
It’s just so sad. To see a life born and so many obstacles already that he has to kind of overcome and then he’s born into a family, a girl that has already all these obstacles. Being young and you know, not educated and her family has a lot of dysfunction as well. A boyfriend that’s pretty much a domestic violence situation.

And,

A lot of the girls I work with are in the situation I was in. The majority are in high school and they are moms. So, you know, they are already up against that. And then up against teachers who are telling them…you know…not just telling them but implying the bad things about being a teen parent, about the look and how hard things are. Well, yea, they already know life is going to be hard, and because they are finding it out just by being pregnant. Being pregnant is hard. And then trying to support a child or trying to not look negative in the eyes of society.

The final conclusion reached by the researcher is that excellent home visitors possess an ecological worldview by truly recognizing the impact of the environment on the individual. One home visitor described the impact on the mother and her future child.

When you are young and you have kids you don’t really fit in a lot of places. You don’t fit in with your friends that were single anymore. If you don’t have a spouse, you don’t fit in with those that are married. You just don’t fit. You don’t quite fit. And my moms tell me that today. ‘I don’t know where I belong. I want to go out with my friends and I want to go have fun’ … and I always explain to them ‘you’ve got yourself in a situation where there are certain tasks that we do…. By becoming pregnant you threw yourself up here into the 20 year old bracket of what their tasks are. Now you are going to have to…you made things harder and you are going to have to finish these tasks back here while society and your parents are going to be expecting you to be working up there. But you got to do these in order to do those right. Otherwise this is going to be missing and you are going to have a big hole and somewhere down the line you are going to have a problem and you are going to have to go back and re-do this in order to get to where you want to be in your development as an adult.’ And I’ll just explain how that works to them and it is going to be hard.

The data pertaining to outstanding home visitors offered numerous insights.

Reconstruction provided five, important characteristics of the stellar home visitors: (a)
Effective at forming and maintaining empathic, therapeutic relationships, (b) Self-awareness, (c) Lifelong learner, (d) Belief in change, and, (e) An ecological approach to working with clients. Besides being useful to administrators in the field of home visitation, this description of the personal characteristics of outstanding home visitors provides a constructive foundation for future research.
Chapter 5: Conclusion

Key Findings

By utilizing the data from research on home visitors perceived as outstanding by their administrators in conjunction with literature from three broad areas (therapeutic relationships, the Nursing Model of Caring, and strengths-based practice), this researcher has concluded that five characteristics best represented these home visitors.

First, the home visitors were effective at forming and maintaining empathic, therapeutic relationships. Forming and maintaining relationships is easier for some people than others. The variables that facilitate the formation of the therapeutic relationships between home visitor and clients include: (a) “good enough empathy” (need not be extraordinarily empathic but at least averagely empathic), (b) positive regard (showing respect to the families and recognizing that the parent is the expert on their child), and (c) congruence.

Secondly, the home visitors possessed the self-awareness necessary for reflective practice. Self-awareness also assists in the forming and maintaining of better client relationships. The three variables for improving therapeutic relationships (“good enough empathy”, positive regard, and congruence) can be improved upon through a long process of reflective practice but this becomes difficult if the home visitor is unaware of their impact on the client relationship. The home visitors were not necessarily introspective but possessed the self-awareness to recognize their own strengths and weaknesses in order to compensate for the aspects of personality that came less easily to them. Although maturity often assists the development of self-awareness, it is not necessary.
Thirdly, the home visitors possessed an attitude of lifelong learning allowing them to reflect on their practice in order to continually improve and expertly perform their work. The knowledge required for home visiting is not that complicated (child development, community resources, curriculum). Translating that knowledge into practice with families is complex and requires patience and a positive attitude during the long training process. Transitioning knowledge into the necessary home visiting skills necessitates reflective practice. Continuous improvement requires home visitors possess a positive attitude towards their own learning and improvement.

Fourthly, the home visitors strongly believed in the ability of their clients to change. Client change was accomplished by focusing on client strengths and empowering practice. Home visitors were also able to focus on their own strengths allowing them to project confidence in themselves and their ability to assist their clients in changing.

Finally, in order for the home visitors to assist parents in therapeutic change, they had a belief in and understanding of systems theory and the impact that the environment can or has had on those clients. Without an ecological approach, home visitors are likely to blame the families with which they work for their unfortunate situations such as poverty. Empowering clients is one way they were able to illustrate this underlying belief.

Limitations of the Study

This research is only a small step in beginning to describe and identify the individuals who may make excellent home visitors. Several cautions are needed.
First, the context of this study may provide a limitation. This study was conducted during a time when financial support for prevention programs was waning. The current downturn in social service funding could change the characteristics of those entering or remaining in the field as caseloads grow and job security is lacking. In some ways the participant home visitors in this study were the ideal. Most entered the field during the expansion of preventative home visitation when training was readily available and programs could afford to send their home visitors to a substantial amount of instruction, often prior to building their caseloads. How these home visitors handle the changes in preventive programs as a result of decreased funding is unknown. It is possible that the changing focus away from quality could drive out the same people who performed to such high standards.

For example, one home visitor described her focus on quality in home visiting as similar to a previous job she held as a waitress. She offered the analogy that as a waitress she only took as many tables as she felt she could anticipate and attend to their needs. She felt that she made as much money in tips as waitresses who took every table they could but made less in tips per table because they were too busy to anticipate and meet their customers’ needs.

Second, this study examined a small number of home visitors who were all Caucasian females. It is quite likely that home visitors from other demographic groups approach their work differently. How this impacts their relationships with clients is unknown.

Third, the methods themselves provide cautions. Although useful in exploring new areas of research, qualitative methods also provide limitations. The intensive, time-
consuming process of prolonged engagement with participants limits sample size. This study involved a small sample from a limited area in the Midwest. The sample comprised of visitors from a variety of home visitation models and this researcher would assert that these home visitors and programs are representative of those across the country. However, this assertion is based only on the researcher’s experience, not research data.

The participant home visitors were identified by their administrators as excelling in the field. However, since the researcher made no effort to quantify this assertion, it is possible that the home visitors were not outstanding. A comparison to average home visitors was not utilized.

Finally, this study is descriptive rather than explanatory, therefore causal connections cannot be claimed. Although a place from which to start, a description of stellar home visitors is unable to delineate the characteristics of those who failed in such work and cannot address the gradations that may exist within each proposed characteristic of outstanding home visitors. For example, does an individual with only a moderate ability to form and maintain relationships perform their work as a home visitor moderately? A more powerful research design could be utilized in the future to measure the five characteristics in larger groups of home visitors across time.

**Future Research**

This description of home visitors excelling in their field offers a foundation for future research. Several suggestions are offered.
Although this study provides a description of home visitors perceived as excellent, it does not quantify what makes a home visitor excellent. The research participants were chosen by their administrators based on the administrators’ criteria and the reason each home visitor was chosen as outstanding was collected. Reasons given by administrators included those related to both the home visitor’s productivity and practice in the field. It cannot be assumed that each home visitor excelled equally in both areas of their work. Future research could examine process and program outcomes at the home visitor level for a better understanding of precisely how these home visitors excelled. For example, what are the rates of client retention among the excellent home visitors compared to others? What measurable changes are seen in their clients as compared to the clients of other home visitors? It would be useful in the future to examine client outcome data and home visitor productivity data to further quantify excellence in home visitation.

This research only examined home visitors believed to be excellent by their administrators. A larger, varied sample combined with home visitor productivity and client outcome data could be used in a cross-sectional design. Measures of the five proposed characteristics could be designed and levels of home visitor performance delineated to see if the proposed home visitor characteristics differed across the levels of home visitor performance. Such methods would make it possible to study the differences in the five characteristics of outstanding home visitors across home visitors that are not as stellar or may even be performing sub-optimally.

The home visitors described their work with clients and provided responses to proposed scenarios. Nonetheless, it would be very useful to see the characteristics in
action by observing home visitors with clients. Directly measuring home visitor performance in the field would be challenging but would offer information beyond what can be accomplished in their descriptions and the scenarios.

This research offers a description of five key characteristics found in the home visitors interviewed. However, whether these characteristics were already present in these individuals prior to becoming a home visitor is unclear. For example, it seems unlikely that an individual who has only a strongly individualistic worldview would enter the field of social work. It is likely that a home visitor’s ecological paradigm would precede their choice of career even if they could not label it as such prior to their education. Similarly, it seems that an individual would not enter the field of social work or nursing without feeling empathy for others. Yet, it is quite possible that the individual is not skilled at expressing that empathy and enhances this skill through additional education, training, experience, and supervision.

Hence, the researcher proposes that some of the characteristics of outstanding home visitors are more open to improvement than others. Based on the data and relevant research, this researcher has hypothesized that some of the characteristics are more amenable to change than others. Hence, the five characteristics are ordered from more to less amenable to change as seen in Figure 2.
Figure 2: Personal Characteristics of Outstanding Home Visitors

- **forming and maintaining empathic relationships**
  - The home visitors were effective at forming and maintaining empathic relationships. Forming and maintaining relationships is easier for some people than others. The variables that facilitate the formation of the therapeutic relationships between home visitor and clients include: (a) “good enough empathy” (need not be extraordinarily empathic but at least averagely empathic), (b) positive regard (showing respect to the families and recognizing that the parent is the expert on their child), and (c) congruence. Although these 3 variables can be improved upon, Klass (1996) claims that they can only be learned through a long process of reflective practice.

- **self-awareness**
  - The home visitors possessed the self-awareness necessary for reflective practice. Self-awareness also assists in the forming and maintaining of better client relationships. The three variables for improving therapeutic relationships (good enough empathy, positive regard, and congruence) can be improved upon through a long process of reflective practice but this becomes difficult if the home visitor is unaware of their impact on the client relationship. Although maturity often assists the development of self-awareness, it is not necessary.

- **life-long learning**
  - The home visitors possessed an attitude of life-long learning allowing them to reflect on their practice in order to continually improve and expertly perform their work. The knowledge required for home visiting is not that complicated but requires patience and a positive attitude during the long training process. The necessary skills can be taught within reflective practice as long as the visitor has a positive attitude towards their own learning and improvement.

- **belief in change**
  - The home visitors strongly believed in the ability of their clients to change. This was accomplished by focusing on client strengths. Home visitors were also able to focus on their own strengths allowing them to project confidence in themselves and their ability to assist their clients in changing.

- **ecological worldview**
  - In order for a home visitor to assist parents in therapeutic change, they need an understanding of systems theory and the impact that the environment can or has had on those clients. Empowering clients is one way to illustrate this underlying belief. Home visitors do not enter a client's home blaming clients for their negative situations. “Given our individualistic culture, it is not given that the average home visitor will take an ecological approach” (Klass, p. 96).
It is this researcher’s belief that all of the characteristics can be taught and improved upon, but entrenched beliefs become less easily manipulated as one goes down the list. Further research is needed to support this researcher’s hypothesis that these characteristics are indeed more or less amenable to change.

Home visitors were asked during member checks if the five characteristics were always present or if they developed them at some identifiable point. This question often received confused looks and responses from the home visitors. There was no clear consensus if the characteristics were part of their original personality, or developed through their education or training. For example, all felt as if they had improved in areas such as building relationships but could not quantify exactly how or when. The home visitors saw their success as the result of all their life experiences. They seemed to think their current characteristics resulted from a complex interplay of their personality, education, training, and work/life experience. This researcher would agree with this assertion but believes more precise information is possible and offers an area for added investigation. Further research is needed to answer this relevant question.

Implications for Policy

This research provides new information to home visiting programs which could be very valuable in the staffing process. This research can be further utilized by administrators trying to locate the individuals who will be excellent at this work. From this research, a general description of outstanding home visitors including their personal characteristics and approach is available. In addition, further analysis has lead this researcher to propose that five of the home visitor characteristics are more important and
useful than others. A description of the personal characteristics of outstanding home
visitors should be useful to home visitation programs, especially the administrators
responsible for choosing the staff that serve as home visitors. Several suggested uses of
the research outcomes by administrators are offered.

First, it is suggested that administrators pay close attention to the relationship a
potential home visitor forms with them in the interview process. The supervisors
interviewed in this study recognized that home visitors skilled at building relationships
with clients were a boon to program income. Home visitors who formed good
relationships with their clients were suspected to have higher rates of productivity
including high rates of client enrollment and retention. This research supports the value
of home visitor’s relationship-building skills. Luckily, this first conclusion (home
visitors are effective at forming and maintaining relationships) should be fairly apparent
to the administrator viewing prospective home visitors. Since good therapeutic
relationships are similar to social relationships, a prospective home visitor should be able
to form a comfortable relationship with the administrator fairly quickly.

Second, this research suggests administrators may want to pay special attention to
the attitude of potential home visitors towards their prospective client population.
Blaming people for their unfortunate life situations is very common in our society but
social work education strives to recognize the environment’s effect on those negative
situations. Again, an underlying ecological worldview may be difficult to instill in an
individual. For example, home visitors cannot do good work with impoverished moms
and their babies if they think it is the mother’s own fault they are poor in the first place.
Such a belief is likely to manifest itself in a judgmental attitude towards clients and may
result in clients feeling worse about their situations and children. The home visitor’s underlying judgmental belief will hinder progress with the client.

Third, home visitation administrators can look for signs of the five stated characteristics of outstanding home visitors. It is likely that interview questions and scenarios could be designed to give administrators an idea of the prospective home visitor’s skills and attitude regarding self-awareness, lifelong learning, belief in change, and the ecological approach. However, in the case of scenarios, it does not appear as if field scenarios have a “right” answer. It is important to recall that the excellent home visitors did not all respond with the same proposed actions to field situations. However, the home visitor’s response and reason for that response would shed some light into their characteristics and whether those characteristics are similar to those of the participants in this study.

It is hoped that by assisting home visitation programs in locating individuals who are most like those that have excelled at the work, this research contributes to child abuse prevention. Any assistance provided in finding the right people to do this work saves time and money wasted on training those that do not excel. By finding people who are a better fit for the challenging job of home visiting, families can be reached more quickly to prevent poor childhood outcomes such as abuse and neglect.

**Implications for Practice**

A description of outstanding home visitors offers some insights for the training of home visitors and social workers in general. Each of the five characteristics of stellar home visitors provides implications for practice.
This research strongly supports the inclusion of research and theory on helping relationships in the social work curricula. Forming and maintaining relationships with clients is not simply helpful, but imperative. The relationship acts as the vehicle through which the worker shared their knowledge and skill with clients. Although easier for some, forming and maintaining relationships is a skill that can be improved. Improving empathic responses is possible via practice, role play, and supervision in an environment of self-awareness and a commitment to lifelong learning. Each of these concepts (relationship, self-awareness, and lifelong learning) is probably addressed at least briefly in home visitor training and social work education. It is less likely that all three of these aspects are clearly linked. It is this interaction of therapeutic relationships, self-awareness, and lifelong learning that needs to be better stressed in training and social work education.

Hopefully, a person would not enter a career in social work or a home visiting position if they did not believe people could change. As mentioned, this fourth characteristic may be an underlying belief and more difficult to alter. In order to support helpers in utilizing their underlying confidence in change, they need knowledge and confidence in the strengths of their clients. Most training and social work education involves some content on strengths-based practice. Unfortunately, it is important to recall that at least one study found that training in strengths does not necessarily result in strength-based practice. It is possible that the learner’s underlying belief in change based on strengths (or lack thereof) could be the key factor in turning knowledge of the strengths model into practice skills. From this research it is hypothesized that those who do not possess a strengths-based view of change are less likely to really break away from
the deficit-based, medical model. Learning to use client strengths is a complex task. Greater time and attention needs to be paid to strengths-based practice in training and social work education so that participants are able to first honestly explore their underlying feelings and beliefs on both strengths and deficit-based models. Then, in order for helpers to put strengths-based beliefs into practice, further preparation, exercise, and feedback from instructors is needed.

In conclusion, the practice wisdom of a small group of outstanding home visitors has provided a useful contribution towards the knowledge base in this field. Practice wisdom is a term used to describe the complex mix of information, assumptions, and judgments that professionals have accumulated (Dybcz, 2004). This research provides a description of the practice wisdom of home visitors. Often discounted as common sense due partly to the lack of empirical evidence for a particular practitioner’s practice wisdom, “practice wisdom has long held a peculiar status in the field of social work. It is both simultaneously recognized and ignored” (Dybcz, 2004, p. 197). Nonetheless, professionals rely on their own practice wisdom for decision-making on a daily basis and the practice wisdom of experts in the field is often rooted in theory and can be supported by research.

The researcher’s conclusions based on the information gleaned from the interviews and scenarios with home visitors considered excellent are consistent with some of the suggestions found in the practice wisdom of Klass (1996) and Brazelton (1992). Klass (1996) writes from her experience as a home visitation administrator and close interaction with two home visitors that she admired. This literature, based on her own experience rather than research, describes her impressions of good home visiting
techniques. Klass’ writings encourage reflective supervision and discuss her suspicion that self-awareness and a positive attitude towards learning assist the home visitor in benefitting from that interaction with the supervisor. The writings of Dr. Brazelton (1992) are a description of what he does naturally in interacting with families as a pediatrician. Although Dr. Brazelton’s practice is quite different from home visiting, his focus on self-awareness and lifelong learning are also supported by this research.

The home visitors, who were generous enough to participate in this research, utilized practice wisdom. It is often difficult to describe the practice of experts because they utilize intuition in their work (Benner, 1982). Benner (1982) describes an expert as one that may struggle with describing exactly what they do or how they do it, but possess a clear vision of what is possible (Benner, 1982). I propose that these home visitors fit this description and deserve to be called expert. This research is one step in describing the characteristics of expert home visitors who do an important and admirable job each day.
Appendix A

THE FULL-LENGTH (30-ITEM) BEES

Please use the following scale to indicate the degree of your agreement or disagreement with each of the statements below. Record your numerical answer to each statement in the space provided preceding the statement. Try to describe yourself accurately and in terms of how you are generally (that is, the average of the way you are in most situations -- not the way you are in specific situations or the way you would hope to be).

+4 = very strong agreement
+3 = strong agreement
+2 = moderate agreement
+1 = slight agreement
0 = neither agreement nor disagreement
-1 = slight disagreement
-2 = moderate disagreement
-3 = strong disagreement
-4 = very strong disagreement

____ 1. I very much enjoy and feel uplifted by happy endings.
____ 2. I cannot feel much sorrow for those who are responsible for their own misery.
____ 3. I am moved deeply when I observe strangers who are struggling to survive.
____ 4. I hardly ever cry when watching a very sad movie.
____ 5. I can almost feel the pain of elderly people who are weak and must struggle to move about.
____ 6. I cannot relate to the crying and sniffling at weddings.
____ 7. It would be extremely painful for me to have to convey very bad news to another.
____ 8. I cannot easily empathize with the hopes and aspirations of strangers.
____ 9. I don't get caught up easily in the emotions generated by a crowd.
____ 10. Unhappy movie endings haunt me for hours afterward.
____ 11. It pains me to see young people in wheelchairs.
____ 12. It is very exciting for me to watch children open presents.
13. Helpless old people don't have much of an emotional effect on me.
14. The sadness of a close one easily rubs off on me.
15. I don't get overly involved with friends' problems.
16. It is difficult for me to experience strongly the feelings of characters in a book or movie.
17. It upsets me to see someone being mistreated.
18. I easily get carried away by the lyrics of love songs.
19. I am not affected easily by the strong emotions of people around me.
20. I have difficulty knowing what babies and children feel.
21. It really hurts me to watch someone who is suffering from a terminal illness.
22. A crying child does not necessarily get my attention.
23. Another's happiness can be very uplifting for me.
24. I have difficulty feeling and reacting to the emotional expressions of foreigners.
25. I get a strong urge to help when I see someone in distress.
26. I am rarely moved to tears while reading a book or watching a movie.
27. I have little sympathy for people who cause their own serious illnesses (e.g., heart disease, diabetes, lung cancer).
28. I would not watch an execution.
29. I easily get excited when those around me are lively and happy.
30. The unhappiness or distress of a stranger are not especially moving for me.
Appendix B

The Myers-Briggs Type Indicator

Instructions:

1. There are 66 questions and ALL of them must be answered.
2. There are no right or wrong answers so be as honest as you can.
3. Don't answer the questions the way you WANT to be or as your job DEMANDS you to be. Think about the real you - who you are without outside pressures.
4. Work fairly quickly - often your first thought is most accurate.

Section A: Choose the BEST Answer

1. I enjoy:
   - talking to people a little more than listening to people
   - listening to people a little more than talking to people

2. Detailed plans:
   - make me feel "boxed in"
   - make me feel good

3. I make friends quickly:
   - Somewhat true
   - Very true

4. At parties, I find that generally:
   - people approach me
   - I approach people

5. I am likely to say, "A place for everything and everything in its place."
   - probably not
   - probably yes

6. When I am by myself for a long period of time, I tend to become:
   - rested
   - restless

Section B: Choose the word or phrase that you find MORE ATTRACTIVE.

7. realities--what's real
   - possibilities--what could be
<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>ability to think</td>
<td>ability to feel</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>financial manager</td>
<td>social worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>using my brain</td>
<td>using my heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>honesty</td>
<td>sensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>present</td>
<td>future</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>fantasy</td>
<td>reality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>“tried and true” way of doing something</td>
<td>new and creative way of doing something</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Remember:** Choose the word or phrase that you find more attractive.

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>analysis</td>
<td>service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>routine</td>
<td>unusual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>empathy</td>
<td>intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>fact</td>
<td>faith</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>variety and action</td>
<td>quiet and reflection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>mind</td>
<td>heart</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
21. write a play
   act in a play

22. reason
   sympathy

Remember: Choose the word or phrase that you find more attractive.

23. imagine
   observe

24. matters of the heart
   matters of the head

25. different
   standard

26. think about it
   talk about it

27. physical
   spiritual

28. dream
   reality

29. stability
   growth

Remember: Choose the word or phrase that you find more attractive.

30. by myself
   with others

31. emotion
   logic

32. offhand
   rehearsed

33. in front of the camera
   behind the camera
<table>
<thead>
<tr>
<th></th>
<th>flight of fancy</th>
<th>scientific certainty</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>social skills</td>
<td>focus and concentration</td>
</tr>
<tr>
<td></td>
<td>manufacture</td>
<td>conceive</td>
</tr>
</tbody>
</table>

Remember: Choose the word or phrase that you find more attractive.

<table>
<thead>
<tr>
<th></th>
<th>emotions</th>
<th>intellect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>socialize</td>
<td>solitude</td>
</tr>
<tr>
<td></td>
<td>fact</td>
<td>emotion</td>
</tr>
<tr>
<td></td>
<td>being noticed</td>
<td>noticing others</td>
</tr>
<tr>
<td></td>
<td>blueprint</td>
<td>brainstorm</td>
</tr>
<tr>
<td></td>
<td>collect information</td>
<td>interpret information</td>
</tr>
<tr>
<td></td>
<td>&quot;wing it&quot;</td>
<td>plan</td>
</tr>
<tr>
<td></td>
<td>serving people</td>
<td>analyzing problems</td>
</tr>
</tbody>
</table>

Section C: Choose the word or phrase that DESCRIBES YOU BETTER.

<table>
<thead>
<tr>
<th></th>
<th>compassionate</th>
<th>objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>marshmallow (soft, caring)</td>
<td>rock (solid, independent)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>47</td>
<td>tidy</td>
<td>relaxed</td>
</tr>
<tr>
<td>48</td>
<td>soft-hearted</td>
<td>fair-minded</td>
</tr>
<tr>
<td>49</td>
<td>lived-in</td>
<td>neat</td>
</tr>
<tr>
<td>50</td>
<td>river (moving, energetic)</td>
<td>lake (quiet, deep)</td>
</tr>
<tr>
<td>51</td>
<td>outgoing</td>
<td>self-contained</td>
</tr>
<tr>
<td>52</td>
<td>organized</td>
<td>free flowing</td>
</tr>
<tr>
<td>53</td>
<td>meditative</td>
<td>outgoing</td>
</tr>
<tr>
<td>54</td>
<td>imaginative</td>
<td>sensible</td>
</tr>
<tr>
<td>55</td>
<td>calm</td>
<td>exciting</td>
</tr>
<tr>
<td>56</td>
<td>ordered and efficient</td>
<td>laid-back and relaxed</td>
</tr>
<tr>
<td>57</td>
<td>innovative</td>
<td>traditional</td>
</tr>
<tr>
<td>58</td>
<td>likes to plan</td>
<td>takes life as it comes</td>
</tr>
<tr>
<td>59</td>
<td>thinks out loud</td>
<td>thinks before speaking</td>
</tr>
</tbody>
</table>

Remember: Choose the word or phrase that describes you better.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>60</strong></td>
<td>make friends quickly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>make friends carefully</td>
<td></td>
</tr>
<tr>
<td><strong>61</strong></td>
<td>logical</td>
<td>sensitive</td>
</tr>
<tr>
<td><strong>62</strong></td>
<td>starting projects</td>
<td>completing projects</td>
</tr>
<tr>
<td><strong>63</strong></td>
<td>flexible</td>
<td>organized</td>
</tr>
<tr>
<td><strong>64</strong></td>
<td>systematic</td>
<td>informal</td>
</tr>
<tr>
<td><strong>65</strong></td>
<td>inner-directed</td>
<td>outgoing</td>
</tr>
<tr>
<td><strong>66</strong></td>
<td>let things happen</td>
<td>decide what happens</td>
</tr>
</tbody>
</table>

Used by permission of David J. Wood, President of TypeFocus Internet Inc.
References


