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OUTREACH PARTNERSHIPS

MICHIGAN STATE UNIVERSITY

EFFECTIVE HOME VISITING FOR VERY YOUNG CHILDREN—2

This is the third in a series of four **BRIEFS** devoted to effective home visiting. This **BRIEF** explores approaches to intervention and content of effective home visiting models.

APPROACHES TO INTERVENTION

The purpose of all home visiting models for very young children is to promote positive short-term and intermediate outcomes[1] for the infant—in health status, emotional well being, social behavior, and/or language and cognitive competence. The expectation is that these short-term and intermediate outcomes will result in positive long-term behavioral and status outcomes for the child.

Outcomes for the infant are accomplished through the parent's knowledge, beliefs, expectations, perceptions, skills, and behavior. These enhancements and modifications accomplished for the parent in the early years may also result in lifestyle changes—long-term outcomes—for the parent.

The task of the home visitor is to support and promote positive nurturing in the way that the parent cares for the infant and the way that the parent and infant relate to and behave with each other. To accomplish this, home visiting models use approaches that reflect their

- primary objective(s)
- assumptions as to how best to access the parent-infant system

[1] Knowledge, attitudes, beliefs, perceptions, expectations, and skills are short-term outcomes. Intermediate outcomes involve changes in behavior. Long-term outcomes are improved conditions or altered status resulting from changes in behavior over a period of time. See **BEST PRACTICE BRIEF** No. 5.

Five approaches to intervention, focusing on different aspects of the parent-infant system can be identified: Service-based, Information-based, Behavior-based, and two Relationship-based approaches. In theory, intervention models can be characterized as predominantly one or the other of these approaches. In practice, home visitors—particularly those who are implementing a comprehensive model—will use elements from multiple approaches.

Service-Based: Access to Services [2]

Designed to reduce life stressors and to support the healthy development of the infant by providing access to resources and community services. May be identified as referral, case management, or service coordination. Depending on the particular model, this component may be operationalized as

- providing information
- assisting the parent in problem solving, and/or
- facilitating access by making a referral call, providing transportation, accompanying the parent to the agency, etc.

See: Comprehensive Child Development Program.[3]

Strengths and Weaknesses

The Access to Services approach is directed towards enhancing the well being of the infant and parent by attending to needs and issues in the family environment.[4] Access to Services is not a necessary part of interventions with low-income families when the public service system provides an adequate safety net or when another agency is attending to these issues.

Facilitating access to services can encourage dependency if the parent does not learn problem solving as part of the process. In paying major attention to contextual issues impacting the parent and the family, home visitors can overlook the developmental and interactional needs of the infant.

Models emphasizing Access to Services make the assumptions that

- needed aspects of parent-infant intervention are available in the community, and
- families need assistance to obtain needed goods and services

The largest evaluation of an Access to Services model, linking low-income families to needed services in accordance with their own goals, found these assumptions not to be the case. The Comprehensive Child Development Project (CCDP), underwritten by the U.S. Department of Health and Human Services, Administration on Children, Youth and Families, was evaluated in 21 locations. Analysis of this experience found that control families, either by themselves or with the assistance of other community agencies, accessed as many services (although with more of a time lag) as the CCDP families. Further, both service and control groups improved in such measures as the child's language and parent's employment. Differences between service and control families in outcomes were found in only one site.
See summary in **BRIEF** *No. 18.*

Attending to immediate crises and needs is used in some models as a way to build the initial relationship between the home visitor and the parent. Moreover, some resolution of immediate needs and crises is often required before the parent can focus on issues related to the infant.

[2] Crisis intervention can be a component of both the Access to Services and the Relationship-based approaches.

[3] References are to summaries in **BRIEF** No. 18.

[4] Services may include one or more of the following resources or others not listed:
- Health agencies: physician, hospital clinic, health department, mental health, substance abuse treatment
- Health insurance coverage: Medicaid, children not eligible for Medicaid
- Income assistance: TANF, food stamps, WIC
- Basic needs: food bank, clothing and equipment, shelter
- Income promotion: high school completion, vocational training, college
- Child care
- Special services: domestic violence shelter, legal assistance, special needs children - coordination
- Informal services: family resource centers, support groups, faith-based organizations

THE PARENT-INFANT SYSTEM CONSISTS OF

PROCESSES

- **the behavior of the mother** vis-à-vis the infant

  Intervention: providing information, modeling, reinforcing the mother's positive interaction and effective caregiving

- **the mother's perceptions and expectations** (mental representation or internal working model) of the infant, of appropriate parenting, of herself—reflecting her experiences as a child, her current issues, and her beliefs and attitudes

  Intervention: helping her to become aware of how her own nurturing experiences and current and past relationship issues are impacting her interaction with her infant

- **the behavior of the infant**

  Intervention: showing, and interpreting for, the mother what the baby can do or is communicating; using videotape, an assessment tool, speaking for the baby, etc.

- **the infant's perceptions and expectations**—reflecting his/her experience with caregiving

  Intervention: changing the parent's responsiveness to and interaction with the infant

- the **context**—the mother's personal relationships, environment, and other conditions affecting the mother and infant

  Intervention: reducing the stresses in relation to basic needs and relationships; increasing social supports

- **the behavior of the father**

  Intervention: involving the father in the intervention with the mother

- **the perceptions and expectations of the father**

  Intervention: identifying the father's special role in relation to support of the mother and education of the infant

These various points of access to the parent-infant system connect to one another. Therefore, impacting one aspect of the system will have reverberating consequences throughout the system.[5]

[5]Adapted from D.N. Stern, (1995), *The Motherhood Constellation,* New York: Basic Books.

Information-based: Education and Guidance

Designed to increase the mother's knowledge and skills, with emphasis on such areas as

- caregiving practices
- the infant's developmental stages—physical, social, emotional, language, cognitive
- promotion of the infant's language and cognitive development

May be identified as "parenting skills" or "developmental guidance" or "infant stimulation." Communication of a standard body of information, often through use of a curriculum, handouts, or videos, is emphasized. *See: Building Strong Families, Parents as Teachers.*

Strengths and Weaknesses

Models using education and guidance assume that assets in caregiving and in parent-infant interaction are a result of knowing, and that presenting the appropriate information or skills through verbal, written, or visual means, or through modeling will positively impact the parent's behavior.

All families that are confronting the tasks of parenting for the first time need some level of information/guidance. The information-based approach works well with motivated parents, but more intensive intervention will be required for those parents whose characteristics and life circumstances prevent them from focusing on their infant's needs.

Behavior-Based: Observation and Guidance

Designed to improve parent-infant interaction through observation of the infant's behavior, interpretation of its meaning, and encouragement of the mother's movement toward responsive behavior. The parent and the infant together are the focus of the intervention. The intervention is individualized.

See: Interaction Guidance, Brief Intervention for Irritable Babies.

Strengths and Weaknesses

This approach has been used effectively in short-term interventions with families to accomplish a limited number of goals. It requires a skilled, professionally trained home visitor who can establish a relationship rapidly. It has been found to be particularly effective with families who are resistant to intervention, young and inexperienced, or cognitively limited.

Relationship-Based: Supportive Counseling

Designed to follow the lead of the parent and support her in reflecting on her present situation. Emphasizes developing a trusting relationship between the home visitor and the parent. The intervention is individualized.

See: STEEP.

Strengths and Weaknesses

This Mental Health approach may be used by paraprofessionals or professionals who have received some training and are supported by on-going supervision.

Relationship-Based: Psychotherapy

Designed to facilitate the parent's understanding of past and present relationships and experiences as they affect the ability to parent her infant. Emphasizes developing a trusting relationship between parent and home visitor. The parent and the infant together provide the focus for the intervention. The intervention is individualized.

See: Infant Mental Health Services, UCLA Family Development Project.

Strengths and Weaknesses

This approach requires a skilled home visitor, professionally trained in therapeutic interventions who understands how to enter into and use the working relationship to enable the parent to better nurture and protect the child. It is well suited for those families where risks to the relationship between the parent and infant are a primary concern or where parental mental illness is a significant factor.

INFORMATION-BASED VS. RELATIONSHIP-BASED APPROACHES

The Information-based Approach, emphasizing parenting skills and child development, is often paired with Access to Services. This combination—identified as an "Information/Resource" model characteristic of public health nursing home visits—was compared with a so-called "Mental Health" model. The target population were women in Seattle with low income and low social support:

- In the **"Information/Resource" model,** the nurse provided information—facts, procedures, and practices—directed at the physical health and development of the child and mother. The nurse also acted as a service coordinator, facilitating access of families to community resources. The parent was a passive recipient.
- In the more process-oriented **"Mental Health" model,** the nurse developed a therapeutic relationship with the parent, demonstrating ways of dealing with interpersonal situations and problem solving—directed at enhancing the parent's social competence in dealing with family problems and developmental issues. The parent was an active participant.

Women experiencing the Relationship-based "Mental Health" approach completed more visits, attained more intervention goals, and had a lower level of depression than did those experiencing the "Information/Resource" model. A greater number of women starting out with low social skills moved to high social skills under the Relationship-based "Mental Health" approach.[6]

Subsequent studies using the two models found that women moving from low social skills to high social skills under the "Mental Health" approach had more social support, higher parent-infant interaction scores, and fewer children assessed as disorganized in their attachment status.[7]

6 K.E. Barnard, D. Magyary, G. Sumner, C.L. Booth, S.K. Mitchell, and S. Spieker, (1988), Prevention of Parenting Alterations for Women with Low Social Support, *Psychiatry,* Vol. 51, pp. 248-253.

7 C.L. Booth, K.E. Barnard, S.K. Mitchell, and S.J. Spieker, (1987), Successful Intervention with Multiproblem Mothers: Effects on the Mother-Infant Relationship, *Infant Mental Health Journal,* Vol. 8 (3), pp. 288-306; C.L. Booth, et al., (1989), Development of Maternal Social Skills in Multiproblem Families: Effects on the Mother-Child Relationship, *Developmental Psychology,* Vol. 25 (3), pp. 403-412.

INFLUENCES ON OUTCOMES

Characteristics of the Population

In accounting for outcomes, characteristics of the population seem to be as important as the intervention approach used. Conclusions are consistent across studies in identifying those for whom interventions are most and least productive.

Positive outcomes from home visiting interventions tend to relate to a specific population or subgroup.

- The Nurse Home Visitation Program in Elmira, New York, found the strongest results for **poor unmarried white adolescents,** a subgroup of the poor single first time mothers who received services.

  Implications for Practice

  Characteristically, nurses do well with adolescents who may be seeking information and support and who perceive the nurse as an authority figure.[8]

- Both the Elmira and Memphis, Tennessee, projects found that **women with low psychological resources**[9] showed the greatest improvement.

  Implications for Practice

  A measure of psychological resources might be useful at intake to establish priorities for service.

There is an interaction between the intervention offered and accepted and the characteristics of the parent.

- **Women who are functioning at lower levels** *(depressed; lacking sense of control, self-efficacy, social skills; or low intelligence)*
  - will receive a greater number of visits when nurse home visitors are permitted to schedule visits on the basis of need *(women with low psychological resources)*[10]
  - are less likely to participate in an intervention with paraprofessional home visitors and parent groups *(younger adolescents with less healthy babies)*[11]
  - are more likely to drop from service when home visitors use an Information/Resource model; are more likely to remain in service when nurse home visitors use a Mental Health (supportive counseling) model (53% vs. 20%) and have better outcomes when a Mental Health model is used (*women who are at highest risk on the basis of education, IQ, social skill and depression)*
  - demonstrated more secure attachment at 13 months when a Mental Health model is used (48% vs. 33%) and more beneficial results in parent-infant interaction and attachment at 2 years *(lower IQ mothers)*[12]
  - have lower participation and difficulties in forming a strong trusting relationship with paraprofessional facilitators and make greater use of crisis intervention (42%) and supportive counseling (68%) but less use of problem solving around parenting issues (21%) *(women who were unresolved and disorganized with respect to loss of an important figure or abuse/trauma in the past, based on an assessment of their childhood attachment memories)*[13]
  - make less use of problem solving around parenting issues (33%) and supportive counseling (33%) *(insecure, dismissing individuals who tended to present idealistic accounts of their past not supported by specific memories, based on an assessment of their childhood attachment memories)*[14]
- **Women who are resistant or whose low intelligence limits their ability to define a problem and work on it**
  - require reinforcement and concrete help or advice in the context of a trusting relationship[15]

8 An unpublished randomized study in Lansing, Michigan, comparing public health nurses and infant mental health specialists found comparable outcomes, but that adolescents stayed in service with nurses, whereas older women stayed in service with the infant mental health specialist.

9 In the Elmira project, psychological resources were defined as sense of control at intake; in the Memphis project, women were assessed with an index composed of measures of intelligence, mental health, coping skills, and self-efficacy. R. Cole, H. Kitzman, D.L. Olds, and K. Sidera, (1998), Family Context as a Moderator of Program Effects in Prenatal and Early Childhood Home Visitation, *Journal of Community Psychology,* Vol. 26 (1), pp. 37-48.

10 Nurse Home Visitation Project.

11 J.D. Osofsky, A.M. Culp, and L.M.Ware, (1998), Intervention Challenges with Adolescent Mothers and Their Infants, *Psychiatry,* Vol. 51, pp. 236-241.

12 Barnard, et al.

13 STEEP.

14 STEEP.

15 UCLA Family Development Project.

- **Women who are functioning at higher levels** *(not depressed; sense of control, self-efficacy, social skills; intelligent)*
  - reach out for information and assistance to nurse home visitors, using telephone contact and requesting or participating in more visits *(women with high psychological resources)*[16]
  - remain in service when the mode of delivery by nurse home visitors is Information/Referral
  - have children with the highest attachment security at 1 year *(women with IQs over 90)*[17]
- **Interventions using the relationship-based supportive counseling or therapy approaches** have reported connections between the level of outcomes achieved and the extent to which the mother can use self-observation to identify and articulate her emotions and to link her current feelings and behavior with her past experiences. Thus,
  - **women who were open, balanced, and honest in their discussion of their childhood relationship experiences** and who were willing to acknowledge the influence of past events (based on an assessment of their childhood attachment memories) were more likely to achieve a positive relationship with the paraprofessional home visitor and to participate in parenting problem solving (69%) or in supportive therapy (84%) and were less likely to need crisis intervention.[18]
  - **women who were better able to develop within the therapeutic process**[19] were more responsive, reciprocal, and empathic in their interactions with their toddlers and their children were more secure.[20]

Characteristics of the Environment

Change is more likely to occur when there are fewer people in the household who might counter the home visitor's messages.

- When there were fewer persons in the household size, **women in Seattle with low social skills** used more therapy and were more likely to change from low to high social skills.[21]
- **When black adolescent mothers in Memphis with low psychological resources**[22] **lived alone,** the greatest change occurred in the home environment. Two dynamics are suggested to account for this outcome: (1) home visitors made more visits to parents who appeared most needy, and (2) those women who lived in their own household had more control over resources and decision making and were better able to change the physical environment and household routines.[23]

  Implications for Practice
  Because a substantial number of first time mothers live with their family of origin, home visitors need explicit strategies for involving the grandparent. In the Memphis study, 67% of mothers of first-borns enrolled in the project lived with the grandmother at intake, dropping to 43% at 24 months.

16 Nurse Home Visitation Program.

17 Barnard, et al.

18 STEEP.

19 The therapeutic sequence is described by Greenspan and Wieder (Level of Therapeutic Process Scale, 1987) as

1. Mother communicates only factual information with no emotional content.
2. Mother discusses relationships but without addressing the feelings involved.
3. Mother uses self-observation to describe a variety of unrelated feelings.
4. Mother makes connection between feelings experienced toward the intervenor, important figures in the past and in the present.
5. Mother shows consolidation of emotional gains made in the course of intervention, including capacity to articulate and endure feelings of loss, anger, sadness involved in termination of the intervention.

Heinike (UCLA Family Development Project Manual, pp.26-27) suggests that the stages in the mother's use of the home visitor in a therapeutic process are

1. discharge of feelings
2. concrete requests for direct assistance
3. social sharing
4. seeking affirmation
5. requesting solutions
6. reflecting on issues involving self, infant, partner, family, etc.

20 Lieberman, Spanish speaking migrants, UCLA Family Development Project.

21 Booth, et al.

22 See footnote 9.

23 Nurse Home Visitation Program.

AN EFFECTIVE INTERVENTION INVOLVES A RELATIONSHIP

Behavioral change for the parent occurs in the context of a relationship between the parent and the home visitor. The relationship is the central mechanism for producing change through supportive counseling and relationship-based therapy interventions.

In any intervention approach, a positive relationship between the home visitor and the parent is necessary for the parent to accept and respond to the home visitor's presence, to hear the home visitor, and to change behavior with the infant. In any intervention model, the rates of passive or active withdrawal from service in the early months are generally indications of the lack of a relationship.

The home visitor's first and hardest task is to **establish the relationship.** The home visitor must establish

- role (an expert? a facilitator? a friend? a support person? a partner?)
- competence as a resource to the parent[24]
- interest and willingness to be supportive
- reliability (will appointments and promises be kept?)

The relationship depends very much on what has been identified as a **family-centered mental health approach.** That is, the home visitor

- listens and responds with empathy
- conveys nonjudgmental understanding of the parent's situation
- recognizes the parent's desire to be a competent parent
- supports and nurtures the parent as the primary caregiver
- is non-intrusive and respectful
- is flexible in undertaking the intervention and responsive to the family's needs

The effectiveness of the intervention starts with the relationship and the extent to which the parent can develop trust in and engage with the home visitor. The positive connection that is developed between the home visitor and the parent in the first six months will be sustained in the second six months even if the frequency of visits is decreased.[25]

The parent's ability to trust the home visitor creates a working relationship that enables her to respond to the home visitor's support and guidance. At the same time, the experience of a more positive interactive relationship models for the mother the desired responsiveness to her infant. The mother's ability to make and sustain a positive trusting connection to the home visitor is a necessary condition for strengthening her relationship with her child.

Various studies have noted that the quality of the relationship between the home visitor and the parent is correlated with more positive intervention outcomes. Thus, for example, positive results are reported as related to

- a more positive relationship between the home visitor and the parent[26]
- the skill level of staff and their ability to respond to at-risk families in an appropriate and culturally sensitive manner[27]
- the ability of the mother to work with the home visitor in the second half of the infant's first year, which predicts both her responsiveness to the infant at 12 months and child development outcomes[28]

24 Nurses can assume a public recognition of their competence as experts in maternal and child health.

25 UCLA Family Development Project.

26 STEEP.

27 Healthy Families, *The Future of Children,* p.171.

28 UCLA Family Development Project.

The Extent to Which the Parent Makes Use of the Intervention

By definition, intervention effectiveness depends on the extent to which the population is able to make use of the intervention. As the previous section on Characteristics of the Parent suggested, some parents are, for whatever reason, more difficult to engage. Where the parent is incapable of sustaining a relationship with anyone, continuing work is impossible.

Professionals seeking to accomplish behavioral change talk about "motivation," "teachable moments" during pregnancy and early infancy, or the incentive to change generated through crisis. The relationship represents the confluence of home visitor skill and parental receptivity.

AN EFFECTIVE INTERVENTION REQUIRES CONTENT

While various home visiting models place their emphasis on different outcomes—health, social, emotional, cognitive—the various aspects of early development are interrelated. Consequently, there is a good deal of commonality in content although approaches vary. Some models are relatively focused; others define themselves as comprehensive, recognizing that parenting is influenced by multiple factors—the family's environment and resources; the parent's support system and social relationships; the parent's knowledge base, mental health, and past history. The environmental or contextual factors are particularly significant for infants in families with multiple risk factors.

What is emphasized and what is accomplished through home visiting depends on

- the model
- the effectiveness of staff in implementing the model
- the fit between the model and the particular segment of the population of infants and parents that enroll in service.

Home visiting models characteristically work with the parent to increase positive outcomes for the child. There is presumed to be a hierarchy of input and outcome that starts with the establishment of a relationship between the home visitor and the parent. The process continues with modifications in the parent's knowledge, attitudes and beliefs, perceptions and expectations that result in changes in the parent's behavior and culminate in improvements in the child's well being and development. In this long chain of inter-relationships, **programs must be very clear about their objectives and about the content—strategies and messages—that is proposed to accomplish the objectives.**

Six content areas, with a list of possible actions, can be described. In total, these actions should not be viewed as characteristic of any single model. Nor would all content or actions be used simultaneously. In responding to the parent's issues, the home visitor is using a sequence of strategies and messages that over the course of visits, in the context of the developmental stage of the child and of the parent, will accomplish the desired objectives.

Attending to Concrete Needs

In the hierarchy of needs for disorganized families, deficits in the necessities of life and current crises represent pressing issues that a parent must attend to before she can consider good child care practices or responsiveness to the infant. When the home visitor assists the parent to access resources and resolve crises, she/he cements the relationship by establishing the parent's perception of the home visitor as a reliable and helpful person.

Attending to concrete needs by providing access to needed goods and services will reduce immediate stress, provide for the physical needs of the infant, and enable the parent to focus on the home visitor's message. Attending to concrete needs will not, however, have a long-term effect on the social-emotional, language, and cognitive development of the child without other elements of intervention.

Actions taken to attend to concrete needs include

- providing information about accessing services
- telephoning for an appointment; coaching the parent to make an appointment
- providing transportation
- being present with the parent and child in particularly stressful situations

Promoting the Parent's Self-Efficacy

Several models (including but not limited to Nurse Home Visitation Program and UCLA Family Development Project) specifically incorporate improving the parent's self-efficacy as a necessary prelude to accomplishing objectives for the infant. An intervention that focuses solely on the parent's well being, however, is unlikely to result in change for the infant.[29]

Actions taken to improve the mother's capacity and competence include

- teaching problem-solving skills, through attending to basic needs, child care decisions, and relationship stresses
- promoting goal setting, one small step at a time
- life planning with respect to
  - deferring the next birth
  - completing high school
  - obtaining employment
- developing social skills (by example and by supporting appropriate behaviors) and encouraging connections to extended family, neighbors, friends, community groups[30]

Some models will include promoting the parent's efficacy in caring for the child in this aspect of intervention.

Promoting the Parent-Infant Relationship

Some models (such as Infant Mental Health Services) will see this as the core of the intervention, viewing parent responsiveness as a precondition to appropriate physical, social-emotional, cognitive, and language development.

Actions taken to encourage responsive parent-infant interaction and to promote the infant's secure attachment to the parent include

- observing the infant and parent, noting responsiveness and quality of interaction
- interpreting the infant's behavior and needs

[29] A meta-analysis of the results of a number of programs suggested that a specific focus on changing parenting behavior was more effective than targeting the parent's well-being. J. Gray and R. Halpern, (1988), Final Report to the National Center on Child Abuse and Neglect quoted in D. Barnett, (1997), The Effects of Early Intervention on Maltreating Parents and Their Children, in M. Guralnick, (1997), *The Effectiveness of Early Intervention,* Baltimore: Paul H. Brookes Publishing Co., pp. 147-170.

[30] Women who moved from low social competency at the start of the intervention to a higher level showed a related improvement in the mother-infant interaction. Adult social skills involving taking turns, attending to cues, etc. were considered to be directly related to parenting an infant, and indirectly to the enhanced ability to deal with service providers, develop social support, and contribute to feelings of self-efficacy. Booth, et al.

- pointing out the infant's responses to the parent
- observing and communicating the strengths of the parent and positive interactions with the infant
- videotaping parent-infant interaction during feeding or play to show the parent the infant's and the parent's behaviors
- guiding the parent in understanding the importance of her relationship to her infant's development
- guiding the parent toward sensitive, emotionally responsive caregiving in interacting with the infant
- supporting the parent's capacities to notice, listen, understand, and respond appropriately to the infant
- modeling appropriate interaction
- encouraging observation, play, speaking, singing, reading
- allowing the parent a safe place to express negative emotions
- helping the parent to understand how her present life circumstances and past history affect and influence her interactions and relationship with her infant

Encouraging Good Child Care Practices

Appropriate child care practices are key to the development of good health and age-appropriate physical development and will be part of the activities of most, if not all, intervention models.

Actions to encourage good child care practices will include

- facilitating access to services for health care for infant and mother
- connecting family to a primary health care provider
- accomplishing well baby visits and immunizations
- encouraging good child care practices in feeding and sleeping
- attending to safety issues in the home
- encouraging continuity and appropriateness in substitute caregivers

Understanding Developmental Stages/Promoting Development

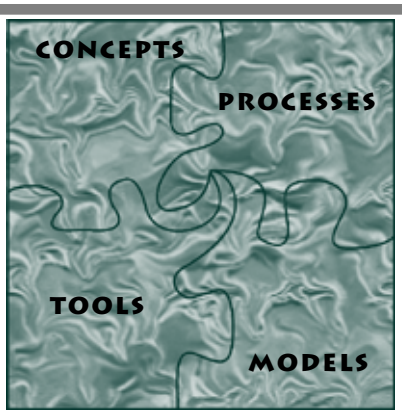
Understanding the sequence of growth and brain development in the early years and the behavior and needs appropriate to the various developmental stages is key to good childcare, parental responsiveness, and the promotion of positive child development.

Actions to promote realistic expectations and appropriate parenting include

- communicating information about brain development and the importance of a stimulating environment and learning opportunities
- communicating the importance of speaking often and positively to young children
- interpreting the meaning of the infant's behavior
- using assessments to indicate what the infant is currently capable of now and in the immediate months ahead
- promoting play and exploratory experiences for the infant
- promoting limit setting and appropriate discipline
- promoting the father's unique role of supporting the mother and providing learning opportunities

Facilitating the Resolution of Relationship Issues

Aversive or non-supportive relationships between the parent and the immediate and/or extended family members have a strong impact on the parent's ability to nurture the infant. Responses to relationship issues have been alluded to briefly in other sections. Some intervention models will consider resolution of relationship issues outside the province of a home visitor.



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THE NEXT BRIEF will cover issues related to Staffing and to Logistics and provide an overall summary.

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