

# **FPRO**

**Family-Provider Relationship Quality  
Measurement Development Project**

## **REVIEW OF CONCEPTUAL AND EMPIRICAL LITERATURE OF FAMILY-PROVIDER RELATIONSHIPS**

**OPRE Report #2012-46**

**November 2012**

# **Family-Provider Relationship Quality**

## **Review of conceptual and empirical literature of family-provider relationships**

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Nicole Forry, Child Trends  
Juliet Bromer, Erikson Institute  
Alison Chrisler, Child Trends  
Laura Rothenberg, Child Trends  
Shana Simkin, Child Trends  
Paula Daneri, Child Trends

Submitted to:

Nancy Geyelin Margie, Ph.D., Project Monitor  
Amy L. Madigan, Ph.D., Federal Project Officer  
Office of Planning, Research, and Evaluation  
Administration for Children and Families  
U.S. Department of Health and Human Services  
Contract Number: HHSP2330095655WC

Project Director:

Christine Winqvist Nord, Ph.D.  
Westat  
1600 Research Boulevard  
Rockville, MD 20850-3129

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## Introduction

The purpose of this literature review is to identify key elements of family-provider relationships in early care and education settings that can be measured in order to assess the quality of those relationships. This review has been undertaken in preparation for the development of a new measure of the quality of family-provider relationships, as part of the Family-Provider Relationship Quality (FPRQ) project (see project overview on page 2). Intended as a companion document for a review of existing measures assessing family-provider relationships (Porter et al., under review), this literature review (1) presents, compares, and contrasts current conceptualizations of family-provider relationships across fields and existing perspectives related to early care and education; (2) proposes a conceptual model that identifies key elements of the family-provider relationship with the purpose of shaping future measure development; (3) reviews existing literature within the framework of the proposed conceptual model; and (4) provides a summary of the reviewed research and suggestions for future research on this topic. The literature review is organized into four main sections reflecting the purposes listed above.

This literature review builds on work conducted in preparation for the “Family-Sensitive Caregiving and Family Engagement Working Meeting: Identifying and Measuring Common Concepts,” which was held in June 2010 by the Office of Planning, Research and Evaluation, in collaboration with the Office of Head Start and the Office of Child Care, of the U.S. Department of Health and Human Services’ Administration for Children and Families.<sup>1</sup> This review specifically integrates and adds to the literature review and tabled summary of existing measures developed for the working meeting, and incorporates and builds upon an analysis of theoretical perspectives developed for a presentation to the annual meeting of the Child Care Policy and Research Consortium in October 2010.<sup>2</sup> The conceptual model proposed in Section 2 of this review is based on an integration of information from these sources, as well as knowledge gleaned from the working meeting and subsequent meetings with experts in the field including the FPRQ Technical Working Group. See Appendix 1 for a complete list of Technical Working Group members.

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<sup>1</sup> A summary of the Family-Sensitive Caregiving and Family Engagement Working Meeting: Identifying and Measuring Common Concepts meeting is available at <http://www.childcareresearch.org/childcare/collaboration.jsp>.

<sup>2</sup> A summary of this session is available at <http://www.childcareresearch.org/childcare/meetings/ccprc/2010/>.

## **Family-Provider Relationship Quality Measurement Development Project Overview**

The Family-Provider Relationship Quality Measurement Development project (FPRQ) is developing a new measure to assess the quality of the relationship between families and providers of early care and education for children birth to 5 years of age. The overall purpose of this new measure is to examine four key constructs related to the family-provider relationship: attitudes, knowledge, practices, and environmental supports. The measure will examine this relationship from both the parent and the provider perspectives, and capture important elements of provider facilitation of family-provider relationships that map onto the constructs listed above. Examples of elements in the measure include attitudes of respect, commitment, openness to change; theoretical/substantive knowledge as well as family/child-specific knowledge; relationship skills including bi-directional communication, sensitivity, and flexibility, and goal-oriented skills, such as collaborating and advocating for families; and environmental supports, such as having an open and welcoming environment.

The goal of this project is to develop a measure that is appropriate for use across different types of early care and education settings, including Head Start and Early Head Start programs, center-based child care, home-based child care, and pre-k classrooms. In addition, a high priority of the project is to make the new measure culturally appropriate for diverse populations, including lower-income and higher-income families, ethnically/racially diverse providers and families, and Spanish-speaking families and providers.

Tasks for the FPRQ project include: (1) reviewing literature on family-provider relationships; (2) developing a conceptual model of the key components of family-provider relationships that promote family engagement and lead to better family, child and provider outcomes; (3) reviewing existing measures; (4) consulting with experts in relevant fields on possible content and format of the measure; (5) holding focus groups with parents and providers, developing items, and piloting the measure; (6) performing psychometric and cognitive testing to ensure the soundness of the measure; (7) developing a final measure to be used for extensive data collection in a variety of care settings; and (8) developing a sustainability plan regarding training on the measure and production of future editions of the measure as needed.

The contract for this project was awarded by the Office of Planning, Research and Evaluation and the Office of Head Start in September 2010 to Westat in partnership with Child Trends, Bank Street College of Education, and the Erikson Institute.

## Notes Regarding Terminology

Three terms used throughout this review warrant definition. First, the term “early care and education” (ECE) refers to all child care and early education settings for children birth to five years of age. This includes center-based programs (i.e., Head Start, pre-K, and community-based child care) and home-based child care programs (family child care, and family, friend and neighbor care providers). Second, our use of the term “parent” throughout this review reflects the current state of existing work, since most published literature and measures on the topic of family-provider relationships focus on the providers’ relationships with parents. However, we acknowledge the role that extended family members play in the lives of children and in relationships with providers and include literature on family-provider relationships when possible. While most of the literature does not yet extend to this larger view of “family” interactions with providers, our intention is to be inclusive of all family members who serve as caregivers. Third, we use the term “providers” to refer to any individuals involved in offering non-parental early care and education to children. This includes center staff (teachers, assistant teachers, aides); center directors; home-based child care providers who offer care in their homes to small groups of children; relative caregivers such as grandparents; and friends and neighbors who provide care that is legally exempt from regulation. In addition, since this is a multidisciplinary review, the term “providers” in this document may also refer to staff within ECE settings who develop relationships with parents to provide parental supports and service referrals (i.e., Head Start family service workers); early intervention specialists; special education teachers; health-related professionals (e.g., nurses, doctors); social workers; child welfare staff; home visitors; elementary/secondary school teachers; or after-school staff.

## Section 1: Introduction and Deconstruction of Existing Conceptual Perspectives

An appreciation for the value of high quality family-provider relationships in early childhood is not novel. Early childhood programs and Head Start, in particular, have historically included the concepts of parent and family involvement as integral aspects of programs and services for children. In fact, the notion that early care and education programs should offer both support to parents as well as education and care for children dates back to the development of infant schools, kindergartens, and day nurseries in the 19<sup>th</sup> and early 20<sup>th</sup> centuries and government-run child care centers for women employed in war-time industries during World War II (Beatty, 1996; Cahan & Bromer, 2003; Rusher & Ware, 1998, p. 3). Although these programs had differing purposes and goals, they each aimed to serve both the child and the parent either through offering a parenting support or a work support in conjunction with care and education for children.

While parent and family involvement has always been central in the early childhood education field, the idea of equal partnerships between providers and families represents a relatively new shift away from earlier deficit approaches in which early childhood programs

were viewed as compensating for poor parenting practices (Powell, 2006). Efforts to support family development and strong family-provider relationships through programs serving families with dependent children were articulated beginning in the 1960s and 1970s by the Family Resource Coalition of America (Family Support America, n.d.). Head Start, founded in the late 1960s, has a legislative mandate, referred to as “maximum feasible participation,” which requires that parents be included in all programmatic efforts and policy decisions (Parker et al., 1997). More recently, the National Association for the Education of Young Children (NAEYC) has included strong parent-provider relationships in their quality standards, as has Head Start and Early Head Start and other two-generation programs (Halgunseth, Peterson, Stark, & Moodie, 2009; Head Start, n.d.; National Association for the Education of Young Children, 2005; National Research Council and Institute of Medicine, 2003; Seitz, 1990). In addition, a majority of Quality Rating and Improvement Systems (QRIS) include family partnerships as one of their standards (Tout et al., 2010), not only to encourage early care and education programs to improve this aspect of quality but also to enhance parents’ understanding of quality child care (Connors-Tadors & Ramsburg, 2008; Porter, Bromer, & Moodie, forthcoming).

Several perspectives exist for conceptualizing the ways providers across settings work with and engage families. However, differentiating among these perspectives is challenging, since many definitions overlap and terms to describe work with families are used interchangeably or have varying definitions depending on the field or context. In the following section, we review three broad perspectives on family-provider relationships which have been applied to early care and education settings. First, the *family support/family-centered care* perspective comes from the related fields of social work, early intervention and special education, and health care. Second, the *parent involvement, family involvement, and family engagement* perspective comes from the early childhood education and K-12 education literature. Finally, the third perspective, *family-sensitive caregiving*, focuses specifically on early care and education providers across settings.

Below, we first provide a description of each perspective, including delineation of the purpose and key principles, examples of conceptual and program models that exemplify the perspective where possible, and a historical context for the perspective. We then compare and contrast the perspectives, pointing to common and unique elements, and briefly discuss Head Start as a program example that integrates all three perspectives. We end the section by discussing challenges of applying these theoretical perspectives to early care and education settings.

### **Family Support/Family-Centered Care**

The terms *family support* and *family-centered care* are often used interchangeably to describe family-provider relationships across diverse settings where children and families are served. Some researchers have described family support programs as examples of family-centered service delivery: “family-centered practice is considered a hallmark of family support



programs, an essential component of family support” (Allen & Petr, 1996, p. 58). Distinctions between these two concepts seem to be related to the breadth of services provided to families. For example, family-centered care models were developed in fields where particular diagnoses or interventions are carried out, such as in the health care or early intervention fields. Family support models of service delivery have been conceptualized more broadly as helping to strengthen and empower families across programs and systems that serve families and children. Given the overlap in these terms and approaches, we attempt here to describe and differentiate the family support and family-centered care models that have been put forth by researchers across fields.

Both *family support* and *family-centered care* are approaches to service delivery that are rooted in an ecological perspective, which recognizes that multiple contexts impact children and families in addition to the home environment (Bronfenbrenner, 1979; Kagan, 1994). Both concepts also recognize that respectful family-provider relationships must also empower families (Dunst, 2002). A *family support* approach to service delivery aims to move families toward self-sufficiency through empowerment, recognition of family strengths, and a prevention rather than treatment approach. It is important to note that there is not one conceptual model for family support, and these programs are housed in a variety of family-focused social service programs, of which early care and education programs are just one. Similarly, *family-centered care* has been described across a range of disciplines including early intervention and special education, K-12 education, early care and education, and health care. Family-centered care may be defined as a philosophy of service delivery that views the family unit (families, broadly defined, and children) as the focus of care rather than only the child (Allen & Petr, 1996). According to Dunst (2002), family-centered care assumes a “set of beliefs, principles, values, and practices for supporting and strengthening family capacity to enhance and promote child development and learning” (p. 139). Family-centered approaches in education, including early care and education, special education, and early intervention, move away from professional-centered models. Rather than viewing professionals as experts who make decisions for children and families based on their perceptions of family and child needs (Dempsey & Keen, 2008), the family-centered care approach to education emphasizes families as resourceful, resilient, and able to make decisions regarding their own well-being. In the health care field, family-centered care has been used with the goal of improving the health and well-being of families and children and improving families’ satisfaction with services received (American Academy of Pediatrics Committee on Hospital Care, 2003; Shelton, Jeppson, & Johnson, 1987).

**Purpose and key principles – family support.** Family support programs emphasize prevention rather than treatment and, as mentioned earlier, take an empowerment rather than a deficit approach to helping families. Family support programs view families as equal partners with providers in achieving goals for children (Kagan & Weissbourd, 1994) and work to build on family strengths rather than try to “fix” families’ perceived weaknesses. A family support perspective takes a developmental view of parents by recognizing that parents have capacity for

growth (Kagan, 1994). In addition, support for the social-emotional development of children and families is emphasized in the family support literature.

The following six principles underlie a family support approach:

1. A health and well-being perspective is valued;
2. Parents' own growth is important;
3. Culture and community are central childrearing influences;
4. Social support is central to family well-being;
5. Child development information improves parenting skills;
6. Support leads to empowerment.

(Weissbourd, 1994)

One well-known program based on the family support model is *Strengthening Families* (Center for the Study of Social Policy, 2004), which aims to promote healthy child development and family well-being. The *Strengthening Families* framework posits several protective factors for promoting healthy families including enhancing parents' social support networks, parenting skills, and links to other services. This framework has been applied most commonly to programs that aim to reduce incidents of child abuse and neglect.

**Purpose and key principles – family-centered care.** Family-centered care approaches also take an empowerment perspective and focus on engaging families in ways that develop their own parenting strengths. Dunst emphasizes that family-centered programs aim to “support and strengthen family capacity to enhance child development” (2002, p. 139). Dempsey and Keen (2008) summarize four principles that underlie a family-centered approach to service delivery in early intervention and special education settings:

1. Families, not professionals, are a “constant in the child’s life” (p. 42).
2. Families understand their children best and are in a position to make decisions for their well-being.
3. Helping the family helps the child (including understanding family context, circumstance).
4. Family strengths and ability to make decisions about their children are emphasized.

Key elements of early intervention and special education programs that use a family-centered approach include both “informal connections” and “formal connections” between professionals and parents (Winton & Bailey, 1997). Informal connections include conversations that may occur at drop-off and pick-up times about the program and about the family, including how the family feels about the program and services offered. Formal connections include what Winton and Bailey (1997) describe as a “well articulated philosophy statement, in which roles and relationships with the family are recognized as central” (p. 17).

Dunst further defines the particular constructs and practice aspects of family-centered care and broadens its application across fields and settings, including birth through high school programs as well as early intervention, home visiting, special education, and early care and education. Specifically, Dunst (2002) defines family-centered practices as consisting of both relational (clinical skills in working with families and professional attitudes toward families) and participatory (individualized and flexible practices with families as well as opportunities for families to be involved in decision-making) practices. In his 2002 analysis of family-centeredness in early care and education programs, Dunst found that most programs engage in relational practices but not both relational and participatory practices.

A second set of principles of family-centered care has been articulated by the health care field. Specifically, a conceptual model of family-centered care in health care settings was originally proposed by Shelton et al. (1987) and more recently has been elaborated and expanded upon by numerous organizations including the American Academy of Pediatrics (American Academy of Pediatrics Committee on Hospital Care, 2003). A summary of these core principles of family-centered care in the health care realm includes:

1. “Family is the constant in the child’s life while service systems fluctuate” (Shelton, et al., 1987, p. 5).
2. Programs show respect for children and families (American Academy of Pediatrics Committee on Hospital Care, 2003).
3. Cultural/ethnic diversity is recognized and respected (American Academy of Pediatrics Committee on Hospital Care, 2003).
4. Parent-professional collaboration is important (Shelton, et al., 1987).
5. Information shared with families is unbiased, honest and complete (American Academy of Pediatrics Committee on Hospital Care, 2003; Shelton, et al., 1987).
6. Services need to be comprehensive in scope (Shelton, et al., 1987).
7. Programs recognize “family strengths and... respect for different methods of coping” (Shelton, et al., 1987, p. 5).
8. Knowledge and application of child development is important in health care (Shelton, et al., 1987).
9. Programs should support families around choice and decision-making related to care (American Academy of Pediatrics Committee on Hospital Care, 2003).
10. Opportunities for peer support are provided and facilitated (American Academy of Pediatrics Committee on Hospital Care, 2003; Shelton, et al., 1987).
11. Health care systems are “flexible, accessible, and responsive to family needs” (Shelton, et al., 1987, p. 5).

**Historical context for family support/family-centered care.** Both family support and family-centered care models of service delivery gained momentum during the 1960s and 1970s, spurred on by the early success of Head Start as well as the recognition that other efforts and systems to help families had failed to meet the needs of many families, especially those living in

poverty. National legislation, which emphasized the importance of family-provider partnerships and the important role of parents and families in programs serving children with special needs ("Support for Families of Children with Disabilities Act," 1994) and in the child welfare system ("Family Preservation and Family Support Act," 1993), helped to legitimize and implement the principles of family support and family-centered care across fields including early intervention, special education, health care, and home visiting.

Meyer and Bailey (1993) outline several factors that have shaped the development of family support and family-centered principles and practices, including families' own stories of insensitive care by professionals; data on limited take-up of services by families; dangers of imposing professional services on families who do not express a need for support; and changing views of how families cope, including ecocultural theory, which emphasizes the importance of the cultural and community contexts of families' lives. Research on brain development underscored the importance of birth to three years of age as a critical period in children's development. Given the research showing the influence of parents and the family on early child development (i.e., Shonkoff & Phillips, 2000), the new attention and urgency which the research on brain development brought to the early childhood field influenced the adoption of family support and family-centered perspectives in programs that serve families with very young children (Kagan & Weissbourd, 1994).

### **Parent Involvement, Family Involvement, and Family Engagement**

Parent involvement, family involvement, and family engagement are terms that have been defined in similar ways in the early care and education and K-12 literature. These related and overlapping concepts share the common goal of enhancing children's learning and development through strong partnerships between schools/programs and families (Epstein, 1995; Halgunseth, et al., 2009; Weiss, Caspe, & Lopez, 2006a; Weiss, Lopez, & Rosenberg, 2010). Conceptualizations of parent and family involvement in early care and education emphasize a range of child outcomes including cognitive development as well as social-emotional outcomes (Weiss, et al., 2006a). Parent involvement models in K-12 focus more narrowly on student learning and academic outcomes and articulate ways schools involve parents in school programming and activities as well as how parents support their children's academic learning at home (Christenson, 2004; Epstein, 1995). The K-12 perspective on parent involvement places children at the center of schooling, with parents and families seen as important spheres of influence surrounding the child. The concepts of "family involvement" and "family engagement" expand and elaborate on these models of parent involvement by including other family members and caregivers in a child's life, describing a more reciprocal model of family-provider partnerships across school and early care and education settings (Halgunseth, et al., 2009; Weiss, et al., 2006a), and articulating a wider range of child and family outcomes. Family involvement and family engagement perspectives also focus on how families support their children's development across settings and the roles that formal settings, such as schools and early childhood programs, play in encouraging and supporting families in this pursuit (Gonzalez-

Mena, 2006; Weiss, Caspe, & Lopez, 2006b; Weiss, et al., 2010). The parent involvement, family involvement, and family engagement perspectives recognize that parents and teachers share responsibility for children's development across domains and that both play necessary roles in children's school success and well-being (Christenson, 2004). They also share the underlying assumption that parents are their children's first teachers.

Despite the existence of pedagogical theories regarding the importance of parent and family involvement in both early care and education settings and K-12 schools, researchers note that efforts to involve and engage parents are implemented inconsistently, have not been systematically integrated into program policies, and often do not engage families in meaningful ways (Weiss, et al., 2010). The Harvard Family Research Project, a leader in family involvement and family engagement work, describes the current landscape of family involvement and family engagement practices in schools as consisting of "random acts of family involvement" (Weiss, et al., 2010). Moreover, Weiss et al. (2010) critique some parent involvement practices as treating parents as "bystanders" rather than active participants in programming for their children. Similarly, Christenson (2004) recommends that in developing school-family partnerships, schools should not only offer activities for involving families, but also hold positive attitudes towards partnerships with families and develop school environments that convey trust, and are welcoming and inclusive of all families.

Recent work by the Harvard Family Research Project and others suggests a move towards a more reciprocal and responsive family involvement and family engagement framework across K-12 and early care and education programs (Gonzalez-Mena, 2006; Halgunseth, et al., 2009; McWilliam, Maxwell, & Sloper, 1999; Weiss, Bouffard, Bridgall, & Gordon, 2009; Weiss, et al., 2010). This new vision of family involvement and family engagement expands the traditional parent involvement model to include other caregivers in a child's life besides parents (extended kin for example) and embraces reciprocal relationships between families and programs or schools. Family involvement and family engagement perspectives recognize that programs and schools play an important role in supporting and strengthening families in their childrearing as well as encouraging families to become actively involved in school events and programs. This perspective also includes an emphasis on the importance of provider/program "funds of knowledge" regarding families' strengths, experiences, and resources (González, Moll, & Amanti, 2005). Researchers hypothesize that increased familial involvement in early care and education settings may lead to enhanced provider understanding of parent perspectives and of parents' goals for children in care (Powell, Son, File, & San Juan, 2010).

**Purpose and key principles – parent involvement.** Epstein's six types of parent involvement (Epstein, 1995, 2008) are widely cited in the K-12 educational literature. Epstein's model focuses on both the parents' role in children's education and learning as well as the school's role in working with families to promote children's school success. This model emphasizes the ways in which parents may become involved in schools and how schools can

facilitate this involvement. It specifically focuses on the elementary and secondary school context:

1. **Parenting:** Programs help all families establish home environments to support children as students.
2. **Communicating:** Programs design effective forms of school-home and home-school communications about school programs and children's progress.
3. **Volunteering:** Programs recruit and organize parent help and support.
4. **Learning at home:** Programs provide information and ideas to families about how to help students at home with homework and other curriculum-related activities.
5. **Decision-making:** Programs include parents in school decisions, and support parent leadership.
6. **Collaborating with the community:** Programs identify and integrate community resources and services to strengthen school programs, family practices, and student learning.

(Epstein, 1995, pp. 18-21)

**Purpose and key principles – family involvement and family engagement.** Family involvement and family engagement have been discussed in both the early care and education and K-12 literatures. Weiss, Caspe, & Lopez (2006a) have articulated three areas of family involvement, including parenting, home-school relationships, and responsibility for learning outcomes. “Parenting” in this model entails parents’ attitudes, values, and practices related to their children’s learning. “Home-school relationships” include both formal and informal connections that families make with programs. “Responsibility for learning outcomes” focuses on the active roles parents take in supporting their children’s learning and extends academic and cognitive child outcomes to social-emotional outcomes such as “social competence” and “positive engagement with peers, adults, and learning” (Weiss, et al., 2006a).

In a recent article, Weiss et al. (2010) put forth a new framework for family engagement in elementary and secondary education that presents a more reciprocal vision in which the focus is not just on families’ involvement in their children’s learning but also on how programs and parents should work together to support children’s learning. This perspective on family engagement articulates three “key elements” for this framework:

1. “Family engagement is a shared responsibility” – Schools support families in their roles with children including families’ supporting their own children’s learning, families’ involvement and partnership with school programming, families’ “advocacy for school improvement”, and families taking on leadership roles in schools.
2. “Family engagement is continuous across a child’s life” – Schools help families focus on children’s learning from early childhood through high school graduation and college.

3. “Family engagement cuts across and reinforces learning in the multiple settings where children learn” – Schools support families in helping children learn outside of school – at home, after school, community-based programs, cultural institutions, etc.

(Weiss, et al., 2010, p. 11)

Halgunseth et al. (2009) also developed a model of family engagement specific to center-based early care and education settings that emphasized the importance of reciprocity and shared responsibility between families and programs, cultural responsiveness of programs toward families, and the importance of professional development for teachers around family engagement work. This family engagement model emphasizes both families’ involvement in their own children’s learning and program/provider support for families’ engagement in program goals. Halgunseth and colleagues posit six factors related to family engagement:

1. Families are viewed as decision-makers and advocates for their children.
2. Two-way communication is practiced with families.
3. Collaborative exchange of information is carried out with families.
4. Learning-at-home activities are encouraged to “extend the teachings of the program”.
5. Supportive home learning environment is encouraged.
6. Professional development for teachers around family engagement is implemented.

(Halgunseth, et al., 2009, p. 3)

**Historical context for parent involvement, family involvement, and family engagement.** As might be expected considering the similarities and overlap between them, the concepts of parent involvement, family involvement, and family engagement come from the same historical roots. Although the terms are often used interchangeably, subtle shifts in language used in the educational literature suggest that earlier parent involvement models presented a more restrictive vision of the role of families in schools both in terms of the narrow focus on parents (not other caregivers in a child’s life) and the view of parents as sharing responsibility for children’s learning at home but as peripheral, passive participants in their children’s school experiences. The more recent concepts of family involvement and family engagement present a more reciprocal vision of family-provider partnerships that may be applied across settings where children spend time and a perspective that views parents as active participants in their children’s development and learning both at home and at school.

The principles of parent involvement in early care and education programs were embraced as part of the establishment of Head Start. Established in 1964 by President Lyndon Johnson as part of the “war on poverty,” Head Start was created as a program to provide low-income four-year-old children early education and comprehensive services. Equally important was the commitment of the program to supporting parent involvement and including parents as partners with professionals (Halpern, 1999). At the time, all of the Office of Economic Opportunity programs were legally obligated to support the “maximum feasible participation” of individuals served, and then this became an integral part of the Head Start program (Kagan,

2002, p. 512). When Early Head Start was established in 1994, it too adopted the parent involvement provisions of the preschool Head Start program and applied the concepts of shared governance, parent participation in the program, and home visitation to the new program serving expectant parents and infants and toddlers. Indeed, woven throughout the Head Start performance standards is an emphasis on the importance of family involvement and support (U.S. Department of Health and Human Services, 2008). More recently, Title IV of the Goals 2000 Act (U.S. Department of Education, 2001) put forth guidelines regarding parental assistance in education programming including efforts to increase parents' competence in childrearing activities and efforts "to strengthen partnerships between parents and professionals in meeting the educational needs of children aged birth through 5 and the working relationship between home and school." In addition, quality standards articulated by the National Association for the Education of Young Children (NAEYC) address the importance of strong family-provider partnerships in early care and education programs (National Association for the Education of Young Children, 2005). Despite this long history of national efforts that emphasize the importance of families in early care and education programs, there is a lack of research on the extent to which the principles of family involvement and family engagement have been consistently applied and implemented across a range of early childhood programs beyond Head Start and other two-generational programs that offer comprehensive services for families.

### **Family-Sensitive Caregiving**

The family-sensitive caregiving model was developed to apply to a range of early care and education settings, including home-based child care (e.g., family child care homes and family, friend, and neighbor caregivers) and center-based settings. Family-sensitive caregiving focuses on provider responsiveness and sensitivity toward the needs of working families with a focus on both family and child outcomes. Influenced by research on the kinds of informal supports that providers offer to families (Adams, Rohacek, & Snyder, 2008; Bromer & Henly, 2009) as well as studies on the challenges families face in balancing their work and home responsibilities (Henly & Lambert, 2005), this perspective is based on several assumptions. One is that parents have the primary influence on their children's development and that providers who are sensitive to family circumstances and needs may strengthen parents in their parenting roles. In this way, providers can affect child outcomes indirectly via the family's influence on the child. A more direct pathway to child well-being focuses on the relationship between program access and affordability and child outcomes: "Children may reap the benefits of the child-centered aspects of high quality programming only if the providers offering such care are accessible, affordable, and available during the days and hours for which families need care" (Bromer et al., 2011, p. 161) .

**Purpose and key principles – family-sensitive caregiving.** Family-sensitive caregiving is hypothesized to consist of three domains: provider attitudes, provider knowledge about families, and provider practices with families (Bromer, et al., 2011). Positive attitudes towards parents are defined as respect and acceptance of diverse family traditions and cultures, child-rearing



practices, and family circumstances. Provider knowledge includes knowledge about the family's employment and economic situation (e.g., work or school schedules), family traditions and cultural beliefs, and awareness of parents' strengths and needs. Family-sensitive practices include frequent and positive communication with families about a wide range of issues related to both the child's and the parent's needs; flexible programming such as varying hours of care to accommodate unpredictable job and payment schedules; and provision of resources and referrals about parenting and other parental needs, as well as opportunities for social support with other parents (Bromer, et al., 2011).

**Historical context of family-sensitive caregiving.** The model of family-sensitive caregiving is the newest perspective on family-provider relationships. Elaborated in a chapter on the role of families in the measurement of early care and education quality (Bromer, et al., 2011), the perspective of family-sensitive caregiving was developed partially in response to research findings that show small but positive impacts of early care and education quality on child outcomes, suggesting that current measurements of quality may be missing some important elements (Burchinal et al., 2009). The model also arose out of the recognition that the work support aspect of early care and education arrangements has been a missing component in most definitions and conceptualizations of quality in this field.

### **Common Principles across the Conceptual Perspectives**

The three conceptual perspectives reviewed here share several common and overlapping principles. Figure 1 summarizes the main tenets of the three perspectives and lists the fields to which these models have been applied. This figure shows that while all three perspectives have been applied in early care and education settings, only family support/family-centered care perspectives have been developed and used in the fields of health care and social work. Additionally, family-sensitive caregiving is the only perspective which draws on research about home-based child care.

# Figure 1. Conceptual Perspectives on Family-Provider Relationships in Early Care and Education

Note. This model was first discussed at the Plenary presentation on Family-Provider Relationships at 2010 CCPRC annual meeting; The model emerged from on-going discussions with Child Trends and OPRE and discussions at the June 2010 Working Meeting on Measurement of Family Engagement and Family Sensitive Caregiving.

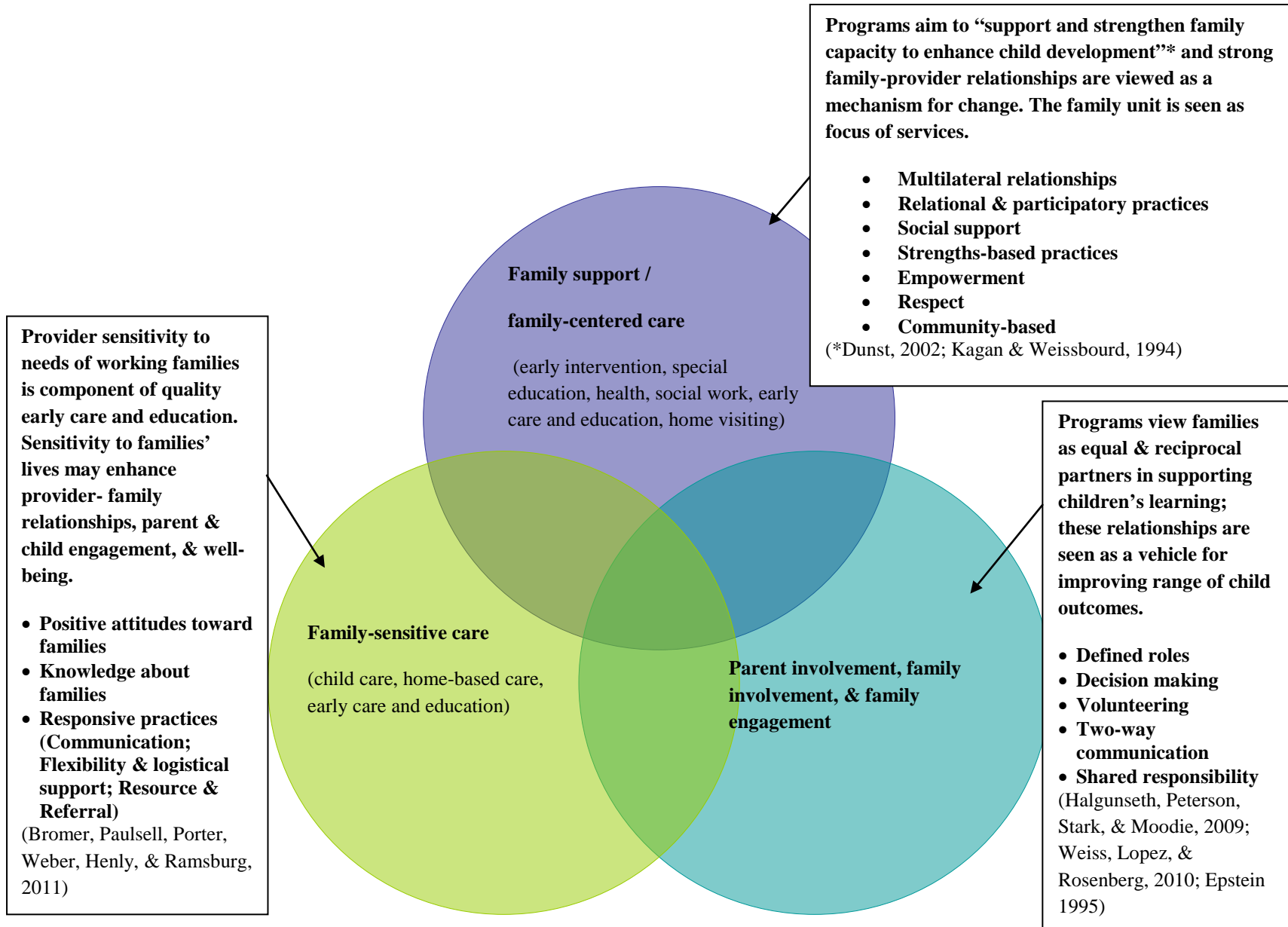


Table 1 outlines the common and unique key principles across the three conceptual perspectives. Five main commonalities are identified in this table. First, the three conceptual perspectives share an ecological view of child development and well-being in which parents, families, communities, and programs are seen as interdependent in the ways they shape children's lives. Second, although the articulated pathways vary by model, all three perspectives are focused on improving child outcomes across domains of development (e.g., cognitive, health, and social-emotional development). Family support/family-centered care articulates an indirect pathway to improved child outcomes; this perspective posits that empowering families and facilitating parental well-being will enhance child development. Parent involvement, family involvement, and family engagement perspectives suggest a direct path to child outcomes; namely, that children's learning will be enhanced by focusing on and supporting parents' active and direct engagement in their children's development across domains. Family-sensitive caregiving articulates both indirect and direct pathways by emphasizing provider responsiveness toward parents' needs as well as provider policies that increase access and participation for children.

Third, in addition to their focus on child outcomes, all three perspectives address the importance of family-related outcomes such as family self-sufficiency, well-being, and efficacy, and recognize that social and peer support are key elements hypothesized to shape and enhance the ways families care for their children. Family support/family-centered care as well as family-sensitive caregiving view adult outcomes as integral to improving child outcomes. In the parent involvement, family involvement, and family engagement perspective, there is variation in this emphasis on parent and family outcomes. For example, Harvard Family Research Project's vision of family engagement recognizes the importance of social and peer support for families in their support of their children's learning (Weiss, et al., 2010), whereas Epstein's types of parent involvement do not directly address adult-related outcomes.

Fourth, all three perspectives take a strengths-based approach to working with families and emphasize the importance of understanding the unique strengths and circumstances of families. And finally, all three emphasize the centrality of family-provider partnerships, although these are articulated differently across models and are often seen as serving different purposes. For example, in the family support/family-centered care perspective, family-provider partnerships are seen as enhancing and supporting a family's ability to advocate for their own needs and goals. In a sense, the partnership or family-provider relationship itself becomes a mechanism for change in family-centered programs and the ways providers interact with families is viewed as a model for intra-familial relations. In contrast, the parent involvement, family involvement, and family engagement perspective views the family-provider relationship as a vehicle for enhancing children's development. The relationship is a means to a well-defined outcome, namely, children's well-being and the development of cognitive and social-emotional competencies.

**Table 1. Common and unique elements across three conceptual perspectives: Family support/family-centered care; parent involvement, family involvement, and family engagement; and family-sensitive caregiving**

Common Elements	Unique Elements
Ecological perspective	Family support/family-centered care:
Child outcomes	<ul style="list-style-type: none"> <li>• Specific practices articulated for practitioners</li> <li>• Focus on empowerment of families</li> <li>• Focus on the family-provider relationship itself as a mechanism for change</li> </ul>
Family-related supports or outcomes	
Strengths-based	Parent involvement, family involvement & family engagement:
Family-provider partnerships	<ul style="list-style-type: none"> <li>• Family-provider relationship is a means to an end/vehicle for enhancing child outcomes</li> <li>• Specific roles for parents and providers</li> <li>• Focus is primarily on center-based early care and education or K-12 schools; has not addressed home-based child care settings</li> <li>• Includes clearly articulated child outcomes related to children’s learning and social-emotional competence</li> <li>• Focuses on extending work of providers/teachers with children to supporting how parents work with children</li> </ul>
	Family-sensitive caregiving:
	<ul style="list-style-type: none"> <li>• Provider attitudes and gathering knowledge as specific domains related to family needs and circumstances</li> <li>• Specific focus on work-related support and employment outcomes for families</li> <li>• Focus on provider outcomes</li> </ul>

**Unique Contributions of the Conceptual Perspectives**

In addition to these commonalities, each perspective has unique elements (Table 1). The family support/family-centered care perspective is the broadest with practices articulated for how providers work with families across the early intervention, education, and health care fields. This perspective places a unique emphasis on empowerment of families as a goal for programs and services. In addition, this perspective has a specific focus on the family-provider relationship itself as a mechanism for shaping family-child relationships. In this perspective, the relationships that providers build with parents are seen as models for relationships parents may nurture within their own families.

In comparison, the parent involvement, family involvement, and family engagement perspective focuses on how parents and families can support children and seeks to improve

outcomes related to children's learning and social-emotional competence. Moreover, while the family support/family-centered care perspective tends to focus on provider or program responsiveness to families, the parent involvement, family involvement, and family engagement perspective focuses equal attention on what parents and teachers contribute to children's development.

The parent involvement, family involvement, and family engagement perspective is unique in its focus on equitable roles for parents and providers within program settings. This perspective is more context-specific than other models in that it focuses on educational settings and the roles of teachers and families around children's development. Early childhood perspectives include a focus on children's cognitive and social-emotional development and K-12 perspectives focus more narrowly on children's learning and school success. Although these perspectives emphasize a range of developmental outcomes for children, the explicit mention of school readiness and success as one of the intended outcomes makes this perspective unique from the others.

The family-sensitive caregiving perspective is distinctive in its articulation of three domains of family sensitivity – attitudes, knowledge of families' lives, and responsive practices – and the hypothesized and potential relationships between these domains. This perspective also articulates the importance of employment supports and outcomes for parents and provider outcomes related to job satisfaction.

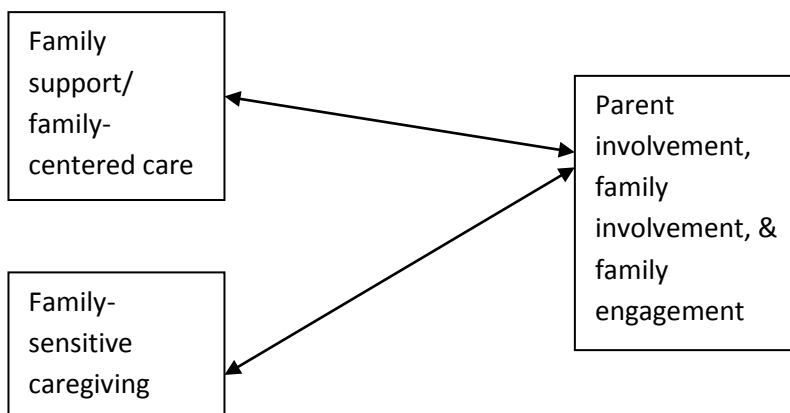
In summary, despite the considerable overlap and common origins and principles of these theoretical perspectives, each one brings a unique viewpoint to the development of strong family-provider relationships. None of these perspectives fully captures all of the aspects of family-provider relationships that may lead to improved family and child outcomes in early care and education settings. Thus, in Section 2, we propose an integrated conceptual model that includes unique components as well as common elements from each of the perspectives described above.

### **Integrating the Perspectives**

As discussed above, each of the perspectives described here contributes common and unique elements to the conceptualization of effective provider facilitation of family-provider relationships in early care and education settings. In order to develop an integrated conceptual model for examining effective provider facilitation of family-provider relationships, we first consider how these perspectives relate to each other broadly (Hutchfield, 1999). As shown in Figure 2, we posit a bidirectional model. First, family support/family-centered care and family-sensitive caregiving may be precursors to parent involvement, family involvement, and family engagement in that families may be more likely to become engaged and involved in their children's development and learning activities when they feel supported, understood, and empowered by programs and providers and when they are better able to balance work and family

responsibilities. On the other hand, during the process of parents becoming involved and engaged in programs, the relationships they develop with providers may lead to providers becoming more sensitive and responsive to the needs of families. Parent volunteering in a program, for example, may facilitate relationship-building between families and providers which may lead to providers having greater understanding of families' needs, more positive attitudes toward families, and more supportive practices. This integration of perspectives provides the basis for the proposed FPRQ conceptual model described in Section 2 of this review.

**Figure 2. Relationships between three conceptual perspectives on family-provider relationships**



Head Start and Early Head Start are perhaps the best examples of programs that embrace an integrated perspective and incorporate aspects of all three perspectives described in this review. The Head Start approach to working with families is clearly articulated in the Head Start Program Performance Standards and Program Regulations (US Department of Health and Human Services, 2008). The parent involvement, family involvement, and family engagement perspective is specified in the Head Start performance standards, which require open access to the program for parents so they can observe or participate in classes and serve on the Policy Council. The Head Start Family Partnerships standards also articulate a family support/family-centered care perspective regarding the importance of both child and family well-being, as evidenced by program standards that require the development of family needs assessments and the promotion of family advocacy and empowerment in order to enhance families' parenting capacity and confidence. Finally, the standards specify several areas which align with the family-sensitive caregiving perspective on the needs of working families, including referrals to employment and educational opportunities, child care, and health care as well as other services related to basic food, shelter, and transportation needs; mental health services; adult literacy; and parenting information and support (US Department of Health and Human Services, 2008).

## **Cautions about Integrating Existing Conceptual Perspectives**

In the next section we will present the FPRQ conceptual model. However, before turning to a model that integrates each of the conceptual perspectives described above, it is important to consider the empirical support for existing perspectives. First, some of the elements articulated in the perspectives described above have not been studied beyond small qualitative studies. The family-sensitive caregiving perspective, for example, presents several elements of family-provider relationships (e.g., flexible programming, work-family-related practices) that have not been tested systematically. Much of the research on program models has occurred through evaluations of multi-faceted interventions that incorporate, for example, a parent involvement or family engagement approach, rather than systematic testing of specific constructs. Thus, evidence on associations between individual components of each of the perspectives described above and child/family outcomes is limited.

In addition, there are a few challenges posed when attempting to apply the perspectives broadly to the field of early care and education. One of the challenges comes from the different contexts in which these perspectives were developed. The principles of family-centered care, for example, come from early intervention and pediatric medical settings, where services are delivered in response to a particular diagnosed problem or need. Additionally, some early care and education settings, such as Head Start, are viewed as targeted interventions with a clearly articulated philosophy and purpose, whereas community-based early care and education providers may not see themselves as part of a broader philosophy or approach, but rather as providing an ongoing service for children or working parents. Another caution in applying these conceptual models across all early care and education settings entails the different levels of staffing and support across settings. For example, the parent involvement, family involvement, and family engagement perspective originates in school-based settings including early childhood center-based programs and K-12 schools, where support staff and training opportunities are likely to be available. The family support/family-centered care perspective has been implemented in two-generation programs where there are often staff who specialize in work with children and other staff who specialize in work with families. While all of these perspectives have been applied to center-based early care and education programs, they are rarely formally applied to home-based child care settings, with the exception of Head Start and Early Head Start. Preliminary evidence from the literature suggests that some of the constructs articulated in the family-sensitive caregiving perspective (e.g., informal social support, flexible hours and fees) may be carried out informally by family child care and family, friend, and neighbor providers (Adams, et al., 2008; Bromer & Henly, 2009). Formally applying the principles of strong family-provider relationships from these various perspectives to home-based child care providers may present a challenge to providers who work alone or do not have access to professional development or training opportunities to help them work with families.

## Section 2: Presentation of the Conceptual Model

Based on existing conceptual perspectives described in Section 1 of this review, empirical and conceptual literature related to family-provider relationships (see Section 3 for details), reviews of the current Head Start and Early Head Start performance standards, and discussions with Technical Working Group members and other experts in the field, a conceptual model centered around elements of effective provider facilitation of family-provider relationships in early care and education settings was developed (see Figure 3). The model was designed to integrate concepts from each of the theoretical perspectives discussed in Section 1 of this review and to articulate (1) potential characteristics or factors that can affect parents' and providers' abilities and willingness to actively participate in a family-provider relationships; (2) elements of early care and education settings identified in the literature as being provider-oriented facilitators of high quality family-provider relationships; (3) intermediate outcomes relevant to families, children, and providers associated with effective provider facilitation of family-provider relationships; and (4) potential impacts of effective provider facilitation of family-provider relationships on families, children, and providers. The structure of the conceptual model and its components are described in detail below.

The FPRQ conceptual model is structured as a logic model in an attempt to visually summarize a complicated issue. Factors that may influence the family-provider relationship, such as characteristics of the family, child, provider, and community, are located on the far left of the model and are hypothesized to influence providers' abilities to effectively facilitate a high quality family-provider relationship. The next column displays elements of early care and education arrangements that facilitate high quality family-provider relationships and which were identified through the review of the literature, consultation with the Technical Working Group, and interviews with experts. Identification and measurement of these elements is the main focus of the FPRQ project. These elements, which will be described in detail below, are organized into four constructs: practices, attitudes, knowledge, and environmental features of the arrangement. Moving to the right, intermediate outcomes associated with effective facilitation of family-provider relationships are detailed. These outcomes include other high quality practices in early care and education as well as intermediate outcomes relevant to children, families, and providers. Finally, impacts, or expected changes resulting from high quality family-provider relationships, are shown at the right end of this model.

Before discussing each component of the conceptual model, a few overarching comments are warranted. First, for simplicity, this model is displayed as a linear process. However, each construct in the model has the potential to be dynamic. For example, as characteristics of the parent, child, and provider change, the family-provider relationship may be altered. Thus, this model reflects a process that changes over time. Though some double-headed arrows are included in the model (e.g., between effective provider facilitation of family-provider relationships and intermediate outcomes) to reflect this interdependence, not all potential double-



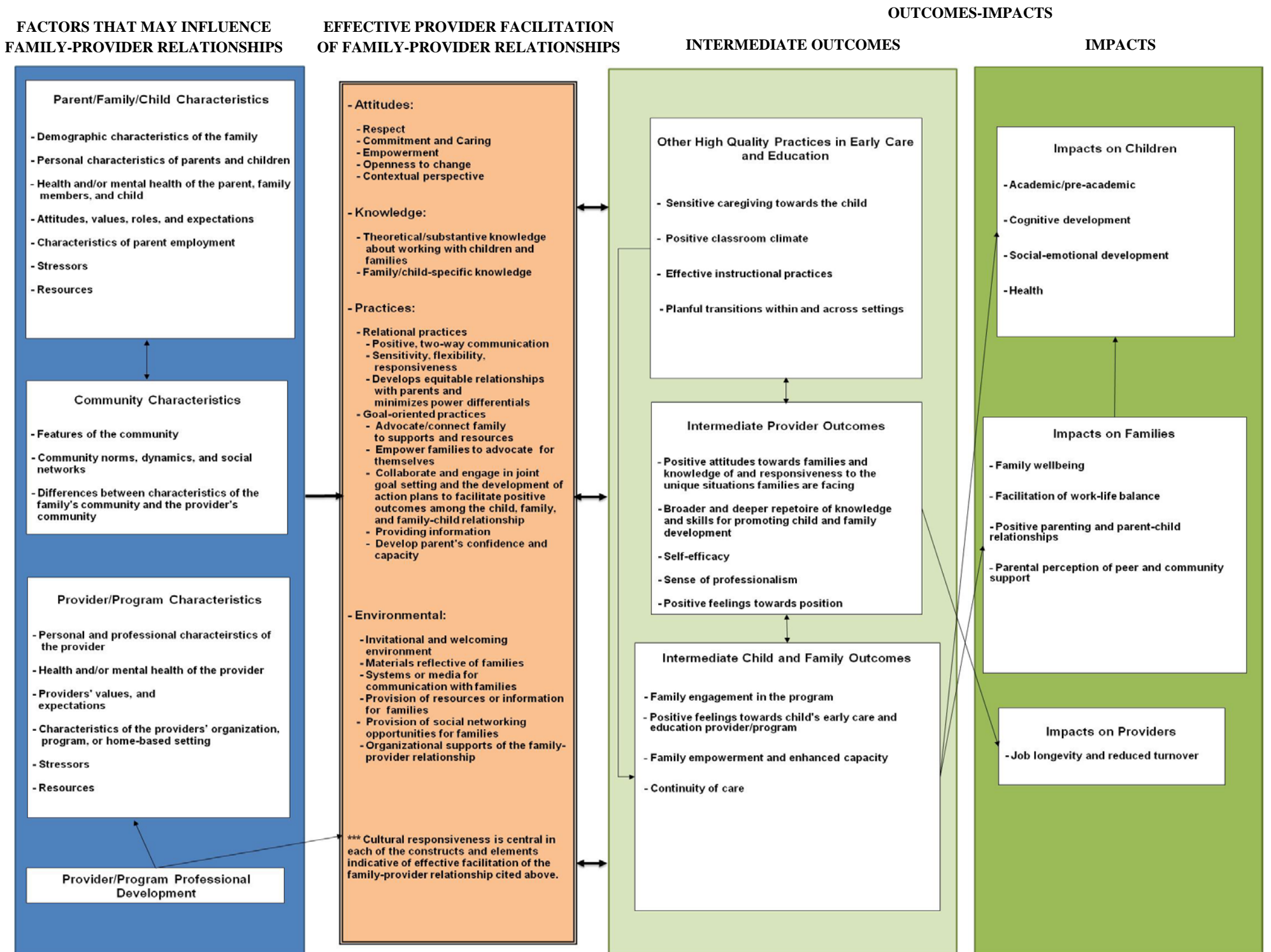
headed arrows are included as this would make the model difficult to read. Additionally, interdependence among constructs in the model can make it difficult to distinguish between factors/characteristics that may affect the facilitation of family-provider relationships, elements of effective provider facilitation of family-provider relationships, intermediate outcomes, and impacts. Distinctions in the conceptual model reflect the available theoretical and empirical literature. However, it is the hope of the research team that future empirical research will further distinguish between and elucidate relations among inter-dependent constructs in the conceptual model.

Second, there are no assumptions as to the amount of time that must elapse before intermediate outcomes or impacts are observed. The lack of temporal assumptions in this model is due to limited empirical evidence on the length of exposure to effective provider facilitation of the family-provider relationship needed to produce intermediate outcomes and impacts. Additionally, intermediate outcomes and impacts included in the model likely vary in terms of both the length of exposure needed before each outcome/impact can be observed and the length of time that must elapse following exposure to effective provider facilitation of the family-provider relationship before outcomes/impacts can be observed.

Third, as the primary purpose of the FPRQ project is to identify and measure critical elements of effective provider facilitation of family-provider relationships across all early care and education settings, our primary focus in the forthcoming review of empirical literature (see Section 3) is on associations closely related to the effective provider facilitation of family-provider relationships. Though other associations in the conceptual model are addressed in the review of empirical literature (e.g., between intermediate outcomes and impacts), sections dedicated to these associations highlight only a sample of relevant literature.

Finally, we acknowledge that the family-provider relationship is bi-directional and inter-dependent, requiring active participation by both providers and parents. As the purpose of the measure to be developed from the FPRQ project is to inform assessment and monitoring of early care and education programs, the central focus of the FPRQ project and conceptual model is effective facilitation of family-provider relationships by early care and education providers and programs (referred to throughout the paper as effective provider facilitation of family-provider relationships). It is the hope of the research team that advancements in the measurement of identified elements of effective provider facilitation of family-provider relationships will support future measurement and empirical research that can be used to define and assess bi-directionally a high quality family-provider relationship.

**Figure 3. Family Provider Relationship Quality Conceptual Model**



## Factors that May Influence High Quality Family-Provider Relationships

Through reviews of the empirical and conceptual research and discussions with experts in the field, the FPRQ research team has identified a number of factors as having the potential to influence family-provider relationships and result in intermediate outcomes and impacts as shown in Figure 3. These factors include characteristics specific to the child, parent, family, provider, and community. A summary of empirical findings related to the associations between identified factors and family-provider relationships are included in the literature review found in Section 3 of this document.

**Parent, Family, and Child Characteristics.** Parent, family, and child characteristics included in the model can be grouped into seven constructs: (1) demographic characteristics of the family; (2) personal characteristics of parents and children; (3) health and mental health; (4) attitudes, values, and expectations; (5) characteristics of parental employment; (6) stressors; and (7) resources. All of these characteristics may have an effect on parents' and providers' propensity and/or ability to engage in the family-provider relationship. **Demographic characteristics of the family** include family income and employment status of family members, family structure, parents' marital status, primary home language, gender of the parent and child, and race/ethnicity. For example, family resources that are associated with demographic features can facilitate or hinder family-provider relationships as they affect the amount of time parents have for communicating with providers, the cultural expectations they have for their relationship with the provider, and their ability to communicate with the provider. **Personal characteristics of individual parents and children** include the parent's education, faith/religion, relationship with child, personality, and literacy proficiency; and the child's temperament. Personal characteristics can affect how a parent relates to others generally, the importance they ascribe to the family-provider relationship, how confident or comfortable they feel during interactions, what expectations and roles they see for themselves and for a provider, and how well they can access and process information given by providers. Likewise, a child's temperament can affect the family-provider relationship as a provider's affinity towards and challenges with an individual child may affect how the provider relates to that child's family. A parent's **health and/or mental health**, for example, limited physical or cognitive functioning of a parent, substance addiction or domestic violence in the household, or mental health diagnoses (e.g., depression, bipolar disorder), may limit the parent's accessibility or ability to engage positively with a provider. Additionally, the health and/or mental health of the child may either result in circumstances that facilitate the family-provider relationship by requiring interactions between the provider and parent or serve as a barrier to family-provider relationships, particularly if the child is absent from care due to a health issue or expelled from care due to behaviors associated with a mental health condition. **Attitudes, values, and expectations**, including parents' personal feelings towards or perceptions of an early care and education setting or provider, expectations regarding their own role as well as the role of an early care and education provider, perceptions of their own self-efficacy, and attitudes towards involvement, may influence family

members' confidence and willingness to engage in a relationship with the child's provider.

**Characteristics of parental employment**, such as work schedule and job demands, can influence a parent's approach or availability to participate in the family-provider relationship as can other **stressors**, such as unexpected life events, instability (e.g., frequent moves or phone disconnections), a lack of adequate resources (e.g., unreliable transportation, inadequate child care for other children in the home) or neighborhood violence at home or in the provider's neighborhood. Finally, **resources**, including close geographic distance from home/work to the child care arrangement, social networks, positive role models, a pre-existing positive relationship with the provider, and other sources of community support, can influence parent's motivation, confidence, and capacity to actively engage in the family-provider relationship.

**Provider/Program Characteristics.** Provider/program characteristics that may be associated with positive family-provider relationships are organized into six constructs, many of which are analogous to those used to describe the parent/family/child characteristics listed above. These constructs include: (1) personal and professional characteristics of the provider; (2) health and mental health of the provider; (3) values and expectations of the provider; (4) characteristics of the organization, program, or home-based child care setting; (5) stressors; and (6) resources.

**Personal and professional characteristics of the provider** may influence his/her approach to family-provider relationships and willingness or ability to engage families in the early care and education setting. These characteristics include both professional characteristics (e.g., education, professional experience, and training) and personal traits (e.g., home language, personality, communication style, personal history/experiences, and whether the provider had a pre-existing relationship with a family) that could influence how the provider interacts with others generally as well as the provider's attitude towards parents and confidence during interactions with parents. Empirical research has demonstrated that providers who feel professionally prepared to engage in interactions with parents are more likely to engage in a high quality family-provider relationship (Bailey, Buysse, Edmondson, & Smith, 1992; Christenson, 2004). Due to the personal nature and intrinsic relational skills involved in a family-provider relationship, traits such as the providers' culture, personality, and communication style are likely to have an effect on the relationship, though these associations have not been documented in the literature.

**Health and/or mental health** of a provider, including symptoms of mental disorders, such as anxiety or depression, and physical conditions that may limit providers' mobility or energy level could affect their capacity for engaging with families. Additionally, providers' **values and expectations**, including any biases, stereotypes, or expectations they have of family members, and perceptions of their own self-efficacy, can also serve as a barrier or facilitator to family-provider relationships. For example, providers who feel they can personally relate to the families of children they care for may feel more comfortable engaging in a relationship with these families. Alternatively, it may be a challenge for providers who hold negative stereotypes towards families with certain characteristics to engage in a respectful and empowering relationship with these families. **Characteristics of the organization, program, or home-based child care setting**, including the type of setting, schedule, job demands, characteristics of

children served (e.g., age, special needs, mixed-age groupings), philosophy and expectations of program leadership, policies, available organization-level supports for providers, organizational practices and atmosphere, and program funding can also affect providers' ability and willingness to facilitate a high quality family-provider relationship. One example of how characteristics of the program can influence the family-provider relationship is evident in comparisons of center- and home-based child care programs as the intimate home contexts, family obligations, and familiarity that characterize home-based child care providers' relationships with parents are often qualitatively different than relationships with parents among center-based providers (Bromer, 2005; Bromer & Henly, 2004; Gibbon, 2002). Finally, as with families, **stressors** (e.g., unexpected life events) and **resources** (e.g., connections with other providers, social networks, and connections to resources in the community) of a provider can affect his/her willingness and effectiveness in engaging families in a supportive relationship.

**Community Characteristics.** Characteristics of the community in which the family lives or, if different, the community in which the provider is located, can also affect the family-provider relationship. **Features of the community**, such as the safety of neighborhoods, median income, geographic features, cohesion in the community, and the coverage, affordability, and accessibility of public transportation, may be associated with unique resources or barriers to facilitating the family-provider relationship. For example, in areas with limited public transportation, families and providers may have less time to communicate with each other due to time constraints imposed by public transportation schedules. Alternately, in cohesive communities, in which parents and providers are unified around a common community goal or vision, family-provider relationships may be easier to cultivate. In addition, **community norms, dynamics, and social networks** may affect family members and providers' opinions or trust of each other. For example, a shared community motto that emphasizes the empowerment of families in facilitating children's education may facilitate communication among families and providers around the skills their children are developing in the early care and education setting or how these skills can be facilitated at home. On the other hand, shared fear among community members in violent neighborhoods may hinder family-provider relationships if parents are preoccupied with the safety of their child or leaving the early care and education arrangement before dark. Likewise, cultural values in the community may influence perceptions regarding the roles of families versus early care and education providers or nuclear versus extended family members that could in turn affect how family-provider relationships are approached. Finally, when families don't obtain early care and education from a provider located in their community, **differences between the characteristics of the family's and the providers' community** may create dynamics that can serve as a barrier to positive family-provider interactions. For example, a low-income family who sends their child to an early care and education provider in a high-income neighborhood may not feel as comfortable interacting with a provider for fear of being judged negatively.

**Professional development.** Professional development is included as a mediating factor between provider/program characteristics and high quality family-provider relationships to highlight the potential of professional development initiatives to improve providers' abilities to effectively facilitate family-provider relationships. The content, intensity, and dosage of accessible professional development opportunities may affect the family-provider relationship through facilitation of positive attitudes towards families; understanding of family functioning, the ecology of child development, culturally-responsive practices, and how to create relationships with families; and effective practices or environmental features used to communicate with and engage families.

### **Effective Facilitation of High Quality Family-Provider Relationships**

The next segment of the conceptual model highlights elements of effective provider facilitation of family-provider relationships. These elements were identified via a review of conceptual and empirical literature and discussions with experts from the field. (For a review of empirical and conceptual literature citing these elements, see Forry, Moodie, Simkin, & Rothenberg (2011)). Identified associations between elements described in this section and intermediate outcomes and potential impacts for families, children, and providers are detailed in the review of empirical literature (see Section 3).

This box in the conceptual model reflects the primary focus of the FPRQ project. Elements are listed for each of four constructs: attitudes, knowledge, practices, and environmental features. In this model, "attitudes" refers to providers' perceptions or beliefs related to interactions with families; "knowledge" reflects information providers have about family systems and ways of interacting with family members as well as specific information about the families they are serving; and how providers' attitudes and knowledge are translated into their interactions with parents is captured in "practices". "Environmental features" reflect the tone, physical environment, organizational climate, and program-level resources/supports for providers and families. Distinctions among these constructs were made to facilitate future measurement development. For example, environmental features were separated from attitudes, knowledge, and practices in preparation for the development of an environmental observation checklist through the FPRQ project. Additionally, elements related to attitudes, knowledge, and practices are distinguished so that question wording can reflect these three unique, but overlapping, dimensions of professional practice (Ajzen & Fishbein, 2005). Before reviewing each of the constructs in-depth, it is worth noting that cultural responsiveness is assumed to cut across each of the constructs.

**Attitudes.** Five attitudes were identified as facilitators of high quality family-provider relationships: (1) respect, (2) commitment and caring, (3) empowerment, (4) openness to change, and (5) having a contextual perspective. Components of **respect** included in the model are: valuing the child and the family; being non-judgmental, courteous/welcoming, and non-discriminatory; being accepting of divergent opinions of parents (e.g., on managing children's

behavior/how to socialize children); and being considerate and patient with parents when trying to elicit changes in their behavior. **Caring and commitment** are reflected through sensitivity to the needs of children, parents, and families; intrinsic motivation, or viewing work as “more than a job”; and being sincere, honest, encouraging, accessible, and consistent in interactions with parents and children. **Empowerment** refers to providers’ beliefs that (1) families are competent and equal partners in fostering children’s development; (2) families have high expectations for their children’s progress; and (3) families bring strengths, competencies, and resources to their children’s early care and education experiences. **Openness to change** refers to a provider’s willingness to alter their normal practices in order to be sensitive to an individual child, parent, or family’s needs, and a provider’s willingness to be flexible in varying their practices based on input received from a parent/family member. Finally, a **contextual perspective** refers to having an appreciation for the broader context in which children’s development and family’s lives are situated and viewing the family as a unit, rather than focusing on an individual child.

**Knowledge.** Knowledge needed to facilitate high quality family-provider relationships includes both substantive/theoretical knowledge and family/child-specific knowledge. For example, **substantive/theoretical knowledge**, such as knowledge of elements/principles of healthy family functioning, benchmarks and activities that facilitate children’s development, adult learning styles, and effective parenting strategies, provides a context for understanding individual children and families and thereby can aid the development of a high quality family-provider relationship. **Family/child-specific knowledge** includes an understanding of families’ cultures; the context in which they live; situations that affect them; community resources that would be helpful to them; and their abilities, needs, and goals. Gathering family/child-specific knowledge through reciprocal information gathering, including providers gathering relevant information about families as well as providers offering families relevant information about themselves and the program, allows providers to be responsive to families and serve as a resource to families, particularly isolated families and families with unique needs or limited resources. This knowledge can also facilitate the family-provider relationship since providers who have an understanding of resources in the community may be better able to respond to families’ needs.

**Practices.** Provider practices posited to facilitate high quality family-provider relationships are based on mastery of both relational and goal-oriented skills. **Relational skills** include the ability to (1) promote positive, two-way communication that is responsive to families’ preferences and providers’ personal boundaries; (2) engage in sensitive, flexible, and responsive support of families’ identified needs and goals; and (3) develop an equitable, culturally-responsive relationship between the provider/program and family that is inclusive of the families’ primary home language. **Goal-oriented skills** include the ability to (1) advocate for families and connect families to peer and community supports/resources; (2) empower families to advocate for themselves, particularly in the transition to other early care and education arrangements, transition to K-12 school, or when trying to obtain social services; (3)

collaborate with and engage families in the program/home-based child care setting through joint goal setting and decision-making and following up on this decision-making process through the development of action plans; (4) provide information on topics such as parenting, health practices, child development, and home-based learning opportunities via accessible parent education opportunities that are sensitive to adult learning styles; and (5) develop parents' confidence and capacity to facilitate their child's development, make informed decisions for their family and child, and follow-up on informed decisions through proactive behaviors.

**Environmental Features.** Finally, five environmental features that may facilitate a high quality family-provider relationship were identified. These elements are: (1) having an invitational and welcoming environment; (2) presence of materials that are reflective of characteristics of the families/children in the early care and education arrangement; (3) systems or media that provide opportunities for communicating with families; (4) provision of information or resources to families, including opportunities for peer social networking, and organizational supports of family-provider relationships; and (5) organizational supports of the family-provider relationship. **Having an invitational and welcoming environment** includes having an open-door policy, inviting parents to participate in the program, encouraging parent input into educational programming, and including parents on advisory boards. **Materials reflective of families** may include books, learning materials, activities, newsletters, or decorations that reflect the cultural and linguistic diversity, occupations, and family composition of families whose children are in the early care and education setting, as well as the cultural community in which these families live. Examples of **systems or media that provide opportunities for communication** with families may include bulletin boards, newsletters, social networking webpages (e.g., Facebook) and other opportunities for parents to communicate with providers using their preferred means of communication (e.g., texting, e-mail, letters in backpacks, and informal conversations at the end of the day). **Provision of information and resources to families** entails providing information about resources offered by the early care and education setting and/or the community. The **provision of social networking opportunities to families** includes opportunities for families to engage in formal and/or informal parent-to-parent or parent-to-provider networking. Finally, **organizational supports** of family-provider relationships include the philosophy of the organization regarding families, expectations for and policies guiding providers' practices with families, and the presence of systems for supporting providers in their efforts to engage in high quality relationships with parents.

### **Intermediate Outcomes Associated with Effective Provider Facilitation of Family-Provider Relationships**

Intermediate outcomes resulting from effective provider facilitation of family-provider relationships are discussed below. These intermediate outcomes include (1) other high quality practices in early care and education, (2) provider outcomes, and (3) family and child outcomes. Intermediate outcomes were identified through reviews of empirical and conceptual literature. A review of empirical literature supporting the associations between effective provider facilitation



of family-provider relationships and intermediate outcomes included below are provided in Section 3.

**Other High Quality Practices In Early Care and Education.** Experts in the field have theorized that a high quality family-provider relationship will moderate the quality of early care and education practices (Bromer, et al., 2011; R. Cohen, personal communication, October 18, 2010). This hypothesis is based on the assumption that providers who have a positive and responsive relationship with families will be attuned to and use information about the child and family to individualize services that best meet the needs of the child and family.

While there are a number of high quality practices in early care and education that could have been included here, the FPRQ conceptual model and this review focus specifically on four practices that were found to be associated empirically with effective provider facilitation of family-provider relationships. These four practices are sensitive caregiving towards the child, positive classroom climate, effective instructional practices, and playful transitions within and across early care and education settings.

**Provider Outcomes.** Indicators of effective provider facilitation of family-provider relationships include providers' positive attitudes towards families and knowledge of/responsiveness to the unique situations families are facing. Intermediate provider outcomes hypothesized to result from effective provider facilitation of family-provider relationships include a broader and deeper repertoire of knowledge and skills for promoting child and family development, a positive sense of self-efficacy and professionalism, and positive feelings towards one's position (e.g., job satisfaction).

**Family/Child Intermediate Outcomes.** Intermediate outcomes associated with effective provider facilitation of family-provider relationships include family engagement in the child's early care and education program/care setting, positive feelings towards the provider/program, feelings of empowerment and enhanced capacity among families, and continuity of care for children. **Families' engagement in the program** reflects one component of families' response to effective provider facilitation of the family-provider relationship. Family engagement includes (1) parents/family members' engagement in early care and education arrangements via volunteer opportunities and other forms of participation including assisting with program decision-making; (2) parents' engagement of children in home activities designed to facilitate the child's development/learning; and (3) parent participation in or utilization of opportunities, services, and resources offered by the early care and education provider/program (e.g., parent nights, dental clinics, holiday parties, etc.). **Positive feelings towards the child's early care and education provider/program** include parent's and child's feelings of satisfaction, trust, and respect for the provider and program. Outcomes related to **family empowerment and enhanced capacity** include parents' confidence in advocating for their child, particularly as they make transitions among and between early care and education settings or between early care and education settings and school; enhanced parental facilitation

of their child's learning and development; parents' skills in making informed decisions, accessing needed resources, and following up on decisions by executing action plans. Outcomes related to **continuity of care** refer to stability of children in the early care and education arrangement, which may result from reduced turnover of children in care due to flexibility on the part of the program/provider, fewer unenrollments by parents who are satisfied with care, and/or fewer children being asked to leave the early care and education setting due to behavioral issues or parental non-compliance with the policies of the setting.

### **Impacts Associated with Effective Provider Facilitation of Family-Provider Relationships**

The final component of the conceptual model reflects potential impacts of effective provider facilitation of family-provider relationships for families, children, and providers. Though some studies have found a direct association between elements of effective provider facilitation of family-provider relationships and impacts included in the conceptual model (e.g., Mendez, 2010; Powell et al., 2010), most studies have found that the association is indirect and mediated by intermediate outcomes in the model. A review of empirical literature supporting associations between effective provider facilitation of family-provider relationships and the impacts included below is provided in Section 3. Additionally, a sample of literature on the mediating associations between intermediate and child, family, and provider outcomes and impacts is provided.

**Impacts on Families.** Potential impacts associated with effective provider facilitation of family-provider relationships include family well-being, facilitation of work-life balance, positive parenting and parent-child relationships, and parental perception of peer and community support. **Family well-being** includes indicators such as the physical and mental health and safety of family members, having an internal locus of control, and positive family relationships. **Facilitation of work-life balance** includes reduced stress around work-family management; greater stability at work; and attainment of educational, literacy, and employment goals. Indicators of **positive parenting and parent-child relationships** include parents' awareness of their rights and ability to advocate effectively for their child when needed; self-efficacy related to parenting; decreased parenting stress; knowledge of child development and strategies for fostering development; awareness of their child's developmental goals, strengths, abilities, and special needs; responsiveness and sensitivity to children in interactions; and provision of a home environment and activities that stimulate children's development. Finally, indicators of **parental perception of peer and community support** include parents feeling connected with peers through networks that enhance their social wellbeing and community life, parents' perceptions of having social support, and parents being able to access available services in their community.

**Impacts on Children.** Four domains of child outcomes are included as potential impacts of effective provider facilitation of family-provider relationships. These domains are (1) academic/pre-academic, (2) cognitive, (3) social-emotional, and (4) health. The **academic/pre-academic** domain of developmental outcomes includes children's approaches to learning (e.g.,

motivation, attention, and persistence), language and literacy/pre-literacy, and subject-specific academic knowledge and skills. **Cognitive** outcomes, such as children's problem solving skills, attention, and task persistence, are often referred to when assessing young children who have not yet developed academic skills. Indicators of **social-emotional development** include having secure attachments, positive social behaviors, and minimal or no problem behaviors. Finally, **children's health** refers to general health as well as the positive management of existing conditions.

**Impacts on Providers.** One potential impact of effective provider facilitation of family-provider relationships on providers that is included in the conceptual model is **provider job tenure**. This refers to providers' tenure in their position, or in the field of early care and education more generally. The association between effective provider facilitation of family-provider relationships and provider job tenure is indirect and hypothesized to result from intermediate provider outcomes included in the conceptual model (e.g., self-efficacy, having a sense of professionalism, and feeling positively towards one's position).

### Section 3: Review of Existing Empirical Literature

The following review of the literature focuses on empirical findings from quantitative and qualitative studies in the fields of health, mental health, social work, family systems, early care and education, and K-12 education. Literature reviews and empirical studies using qualitative and quantitative methods from peer-reviewed journal publications, book chapters, and reports are included. Literature was found through a series of comprehensive and iterative searches on academic research databases including *Psychology & Behavioral Sciences Collection*, *ERIC*, *Medline*, *Social Sciences Abstracts*, *PsycINFO from the American Psychological Association (APA)* and *SocINDEX* via the *EBSCO Host Database*, Internet web searches, library collections, and suggestions from experts in the field. A variety of types of relevant literature are summarized in this review, including literature reviews, experimental and quasi-experimental studies, longitudinal survey/observational studies, quantitative analyses of secondary data, ethnographies, and qualitative studies based on semi-structured interviews and focus groups.

The conceptual model presented in Section 2 serves as a framework for the organization of the literature review. In selecting literature, we sought out studies and conceptual articles that focus primarily on family-provider relationships. We included in this selection criteria literature that discusses factors associated with positive family-provider relationships, descriptions of effective provider facilitation of family-provider relationships or interventions that target the development of family-provider relationships, and antecedents of effective provider facilitation of family-provider relationships as it relates to children, families, and providers. Since our primary focus in this review was on identifying empirically-supported elements of effective provider facilitation of family-provider relationships, sections of the literature review that are more distal to family-provider relationships in the conceptual model (e.g., associations between family and child impacts) include only a sampling of available literature. In order to benefit

from and to contextualize knowledge about family-provider relationships in fields other than early care and education, an attempt was made to specify who “providers” are in each reviewed study.

### **Factors Associated with Family-Provider Relationships**

**Parent, Family, and Child Characteristics.** As described in detail in Section 2, parent, family, and child characteristics included in the model are grouped into seven inter-related constructs: demographic characteristics of the family; personal characteristics of parents and children; health and mental health; attitudes, values, and expectations; characteristics of parental employment; stressors; and resources. Research on the associations between these factors and parents’ participation in/perceptions of family-provider relationships among families with a wide range of characteristics is summarized below.

*Demographic and personal characteristics of family members.* There is mixed evidence regarding associations between family demographics and personal characteristics of family members, and family-provider relationships. Two studies found demographic features of the family to be unrelated to the family-provider relationship. Adams and Christenson’s (1998) study of the level of trust in relationships between parents and teachers found no difference in the likelihood that parents reported trusting their provider by income or ethnicity. Likewise, DeChillo, Koren, and Schultze (1994) found no significant differences in levels of collaboration between mental health professionals and families by the demographic features of the family.

Other studies have documented associations between family demographics, personal characteristics, and family-provider relationships. Denboba, McPherson, Kenney, Strickland, and Newacheck (2006) analyzed the 2001 National Survey of Children with Special Health Needs and found that parents of children with special needs were less likely to feel a sense of partnership with their child’s provider if they were living in poverty, were an ethnic/racial minority, did not have health insurance, and had children with lower levels of functional abilities. Additionally, Pena (2000) found language to be particularly influential in determining the activities parents chose to participate in at their children’s school. Though many parents in this study spoke Spanish, parent meetings were led in English, leaving parents feeling alienated and resulting in a lack of parent participation in parent-teacher meetings.

McWayne, Campos, & Owsianik (2008) and Trivette, Dunst, and Hamby (2010) found mothers to have higher levels of school involvement than fathers. Positive correlates of father involvement, identified by multiple authors, include marital and residential status, with married and residential fathers being more involved; active involvement of the mother; higher educational attainment; gender of the child, with fathers of boys being more engaged than fathers of girls; and primary home language, with a language match between father and provider being associated with more involvement (Fagan, 2007; McWayne, Campos, et al., 2008; Palm & Fagan, 2008; Trivette, et al., 2010).

A multivariate study by McWayne, Campos, & Owsianik (2008) found a number of demographic and personal characteristics of family members predicted mother/father involvement in Head Start. Specifically, when child gender, language, maternal education, employment status, marital status, and parental satisfaction of contact with the Head Start program were considered, McWayne, Campos, et al. (2008) found mother's involvement with school-based activities (e.g., volunteering, participating in class trips) to be positively predicted by satisfaction with their contact with the Head Start program. In addition, mother's involvement, as measured by communicating with Head Start staff about their child's experiences and ways to promote education at home, was predicted by both satisfaction of contact with the Head Start (positive association) and educational status, with mothers who had less than a high school degree being less likely to communicate. In the same analyses with fathers, McWayne, Campos et al. (2008) found father's involvement in school-based activities to be positively predicted by satisfaction with their contact with the Head Start program and negatively predicted by speaking a language other than English (specifically Polish or Spanish). Fathers' engagement in communication with the Head Start program about their child's experiences and ways to promote learning at home was associated with (1) child gender, with fathers being more likely to communicate if they had a male child; (2) language, with fathers who spoke Polish being less communicative than fathers who spoke English; and (3) satisfaction with their contacts with the Head Start program (positive association).

***Health and mental health.*** Health and mental health of the parent may influence his/her propensity to engage relationally with a provider as well as the parent's perception of the family-provider relationship. For example, mental illness and substance addiction among parents has been documented as a barrier to parent engagement in early care and education settings by multiple authors (Littell, Alexander, & Reynolds, 2001; Sheppard, 2002). Littell et al. (2001) found both substance abuse and mental illness to be negatively associated with parent engagement in child welfare services. Likewise, Sheppard (2002) found mothers with depression to be less likely to participate in child welfare services, particularly when child welfare workers were authoritative in their interactions. Finally, O'Neil, Palisano, and Westcott (2001) found most of the variance in mothers' perceptions of providers' family-centered behaviors could be attributed to parental stress, with less stressed mothers perceiving providers to engage in more family-centered behaviors while providing early intervention compared to more stressed mothers.

Special needs of children (physical, behavioral, emotional, or cognitive) and child temperament may actually facilitate a family's relationship with a provider. For example, Adams and Christenson (1998) found parents of children receiving more intensive special education services to display significantly higher levels of trust than parents of children receiving less intensive special education services. A difficult child temperament may facilitate the family-provider relationship if parents look to the provider for tools or strategies to assist with parenting (Kalmanson & Seligman, 1992). Alternatively, though it has not been documented

with empirical findings, parents whose children have a difficult temperament may choose to be less engaged in the family-provider relationship in order to avoid confrontations with the provider regarding the child's behavior.

***Attitudes, values, and expectations.*** Attitudes, values and expectations of parents can also influence their comfort or willingness to engage in a family-provider relationship. Researchers have found parents who have positive feelings towards an early care and education setting are more likely to be involved in the setting (Gockel, Russel, & Harris, 2008) and those who perceive a lack of responsiveness to their needs are less likely to participate in either the setting or a family-provider relationship (Christenson, 2004). Similarly, Pena (2000) found Mexican-American parents' feelings towards the school principal to influence their involvement in school. Specifically, parents who perceived the principal to be unwelcoming or not genuine were less likely to be involved. Additionally, a parent's confidence and his/her expectations regarding the role of a parent versus that of an early care and education provider in educating a child could influence the way he/she approaches the family-provider relationship. For example, Reich, Bickman, and Heflinger (2004) found parents who had positive perceptions of their own general self-efficacy to be more likely to engage in family-provider collaboration. Parental expectations for the parent-provider relationship and attitudes towards involvement have also been associated with family members' engagement in their child's early care and education setting (Fagan, 2007; Knopf & Swick, 2007). For example, Fagan (2007) found some mothers to have low expectations for father's involvement in early care and education settings. Fagan theorized that such expectations may contribute to a low level of father involvement.

***Characteristics of parental employment.*** Characteristics of parental employment, such as work schedule and job demands, can influence a parent's approach or availability to participate in a family-provider relationship. Christenson (2004) and Pena (2000) both found families' time constraints to be a major barrier to participating in a family-provider relationship. Likewise, in their study of parent involvement within Head Start programs, Castro, Bryant, Peisner-Feinberg, and Skinner (2004) found that, among parent characteristics, parent employment is the strongest predictor of parent involvement.

***Stressors.*** Stressors, such as unexpected life events, fear of an unsafe community, and instability (e.g., frequent moves or phone disconnections) can negatively affect families' ability to engage in a family-provider relationship. Brookes, Summers, Thornburg, Ispa, and Lane (2006) identified family crises, stressors, and disorganization as impediments to parent involvement in Early Head Start. Based on analyses from the Head Start Family and Child Experiences Survey (FACES) study, concerns for safety was one identified barrier to parent involvement in Head Start among Latino families (Garcia & Levin, 2001). Likewise, Waanders, Mendez, and Downer (2007) found neighborhood disorder and economic stress to be negatively associated with parent involvement.

**Resources.** Resources, including social networks, a pre-existing relationship with the provider, other sources of community support, and a conveniently located provider may facilitate parents' motivation and capacity to actively engage in family-provider relationships. For example, Brooks et al. (2006) found parents' social support facilitated their involvement in Early Head Start. Fagan (1994) found that parents who worked within one mile of a child care center to spend significantly more time at the center than parents who lived more than one mile away. Alternatively, a lack of resources (e.g., accessible transportation, child care) may hinder families' engagement in a family-provider relationship. For example, Christenson (2004) cited lack of transportation, child care, and positive role models as hindrances to families' engagement in the family-school relationship. Additionally, in Garcia and Levin's (2001) study of Head Start involvement, the need for child care and a lack of support from family members were identified as barriers to parent involvement among Latino families.

**Provider/Program Characteristics.** Provider/program characteristics associated with positive family-provider relationships are organized into six constructs, many of which are analogous to those used to describe the parent/family/child characteristics listed above. These constructs include: personal and professional characteristics of the provider; health and mental health of the provider; values and expectations; characteristics of the organization, program, or home-based child care setting; stressors; and resources. Though literature was not identified to support all of the associations proposed in the conceptual model, associations that were documented are summarized below.

**Personal and professional characteristics of the provider.** Characteristics of the provider that may influence the provider's approach, perceived self-efficacy, and/or willingness to engage in a family-provider relationship include both personal and professional characteristics, such as home language, personality, communication style, personal history/experiences, whether the provider had a pre-existing relationship with the family, education level, professional experience, and training. Though no empirical research was found on the association between personal characteristics of providers and their relationships with families, research was found to address associations between providers' professional experiences and family-provider relationships. Knoche, Sheridan, Edwards, and Osborn (2009) found providers' years of early care and education experience and level of education to be positively associated with the success of an intervention designed to "strengthen parent responsiveness, confidence, and competence" (p. 6) during interactions with their children. Likewise, King et al. (2003) found participation in training on family-centered practices and professional experience to be predictive of staff attitudes about offering family-centered care.<sup>3</sup> Finally, providers in studies by Christenson (2004) and by Bailey, Buysse, Edmondson, and Smith (1992) reported that a lack of training and confidence were barriers to engaging families in a relationship.

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<sup>3</sup> Please note, other literature on the associations between professional development interventions targeting improved family-provider relationships and subsequent provider attitudes, knowledge, and practices is discussed later in this review.

***Health and/or mental health of a provider.*** No empirical literature addressing the association between the health/mental health of providers and family-provider relationships was found. However, extant literature does support a negative relationship between depression among providers and high quality practices (e.g., Hamre & Pianta, 2004; Pianta, et al., 2005; Weaver, 2002).

***Values and expectations of providers.*** Providers' values and expectations, including their attitudes towards families in the program, biases, stereotypes, and expectations they have of family members and their own role as an early care and education provider, can serve as a barrier to or as a facilitator of family-provider relationships. For instance, in his review of the literature, Dunst (2002) found that positive attitudes towards families among school personnel are associated with "positive and productive family-school relations" (p. 143). O'Neil et al. (2001) found physical therapists' attitudes towards families to be predictive of families' ratings of the therapist as respectful and supportive. Additionally, Christenson (2004) identified educators' ambiguous commitment to working with families as partners, stereotypes and doubts about families, fear of conflict with families, and perception of families as having a narrow role in the educational system as barriers to engaging families in relationships. Finally, in their conceptual review of father involvement, McBride and Rane (1997) acknowledged that some administrators and teachers are resistant to invest limited resources into building relationships with fathers, specifically, due to low their expectations for the roles of fathers in supporting children's development.

***Characteristics of the organization, program, or home-based child care setting.*** Select characteristics of the organization, program, or home-based child care setting have been associated with providers' approach to relating with and engaging families. Burton (1992) found an association between type of care and providers' beliefs about both parents' interests and abilities regarding childrearing and the provider's own self-competence in relating to families. Specifically, public school early childhood teachers reported less positive views of families and their own competencies than did Head Start teachers. In their conceptual article, Christenson (2004) cited program funding/resource constraints as a barrier to family-provider relationships. O'Neil et al. (2001) found that early intervention policies that prevented physical therapists from individualizing services and administrative issues, including paperwork demands and management of workload, hindered therapists from engaging in family-centered practices. Likewise, qualitative studies find that home-based child care providers develop closer relationships with families than do center-based teachers. For example, Gibbon (2002) found co-occurrence of family support roles and close provider-family relationships in family child care settings compared to centers. Similarly, in a small qualitative study of providers, Bromer and Henly (2009) found that some center teachers, compared to family child care providers, reported feeling limited by center policies in the kinds of help they can offer families.



***Stressors and resources.*** No empirical research was found associating stressors and resources experienced by providers and effectiveness in engaging families in a supportive relationship.

**Community Characteristics.** Limited literature on the association between community characteristics and the family-provider relationship was identified in this review. In her longitudinal qualitative research, Delgado-Gaitan (2004) found community norms and dynamics to affect family members and early childhood educators' opinions or trust of each other. According to the Social Network framework (Lin, 2001), social networks can play a significant role in moderating these dynamics (Chaudry, Henly, & Meyers, 2010).

### **Associations between Indicators of Effective Provider Facilitation of Family-Provider Relationships and Intermediate Outcomes**

Identifying associations between effective provider facilitation of family-provider relationships and intermediate outcomes as well as impacts on families, children, and providers are of paramount importance in this review, as a central goal of the FPRQ project is to develop a measure that is predictive of desired outcomes for families, children, and providers. Before reviewing identified associations between effective provider facilitation of family-provider relationships and intermediate outcomes/impacts, two cautions warrant mention. First, cleanly compartmentalizing findings from studies into the specific elements and outcomes listed in the FPRQ conceptual model is a challenge as many of the constructs in this model are related and overlap. To the greatest extent possible, we delineated associations between specific attitudes, knowledge, practices, and environmental features identified as being facilitators of family-provider relationships and intermediate outcomes and impacts; however, these distinctions are not always clear cut due to the nature of the constructs and the literature. Second, since the methodology and rigor of cited studies varies widely, caution must be taken when interpreting associations from the literature between elements of effective provider facilitation of family-provider relationships and associated intermediate outcomes and impacts. For this reason, when discussing associations between effective provider facilitation of family-provider relationships and intermediate outcomes and impacts among families, children, and providers, more detailed information on study methodology is presented. This information is included with the intention of distinguishing between causal (e.g., from experimental studies) and non-causal associations and to assist the reader in assessing the rigor of cited studies.

**Associations between Effective Provider Facilitation of Family-Provider Relationships and Other High Quality Practices in Early Care and Education.** There has been little research dedicated to the association between effective provider facilitation of family-provider relationships and other high quality practices in early care and education. Haynes, Comer, and Hamilton-Lee (1989) found a positive association between effective provider facilitation of parent involvement and positive classroom climate in a study of 276 parents whose children were in elementary school classrooms. However, improvements in classroom management may have resulted from components of the intervention that were unrelated to the family-provider relationship. Likewise, Webster-Stratton, Reid, and Hammond (2001) found a positive association between a Head Start intervention that aimed to enhance the parent-teacher relationship and classroom practices and positive classroom management. Finally, though they did not test this association, Powell, Son, File, and San Juan (2010) theorized that parental perception of provider responsiveness is associated with provider sensitivity.

**Associations between Effective Provider Facilitation of Family-Provider Relationships and Provider Outcomes.** Elements of effective provider facilitation of family-provider relationships have been positively associated with providers' feelings of competency, self-efficacy, and connectedness with families, and enhanced skills in communicating with families. For example, in their meta-analysis of eight studies using self-report, observational, and investigator-administered scales, Trivette et al. (2010) found engagement in family-systems practices by providers in early childhood interventions, family support, human services, and health care programs was positively associated with providers' perceptions of their own self-efficacy and perceived control over help-giving practices. Likewise, Brown, Knoche, Edwards, and Sheridan (2009) used a qualitative case study approach with 28 teachers to evaluate the Getting Ready Project, designed to support bi-directional information sharing among parents and early childhood educators, joint attention to children's needs, mutual goal setting, and shared decision-making. As part of the evaluation, Brown et al. (2009) found teachers reported increased feelings of confidence, competence, and self-efficacy; improved communication and partnership-building with families; and development of more professional goals related to strengthening the home-school connection. In their qualitative study, Kaczmarek, Goldstein, Florey, Carter, and Cannon (2004) interviewed six preschool teachers who participated in a family-centered preschool intervention. Teachers reported improved team development and communication between teachers and parents. No studies addressing the association between the family-provider relationship and positive feelings towards one's position were found.

**Associations between Effective Provider Facilitation of Family-Provider Relationships and Intermediate Family and Child Outcomes.** Blue-Banning, Summers, Frankland, and Nelson (2004) described family-provider relationships as being "an intermediary outcome or one of several critical prerequisites for successful student and family outcomes" (p. 182). Here we review literature on documented associations between elements of effective provider facilitation of family-provider relationships and intermediate outcomes for families and

children specified in the conceptual model. Intermediate family and child outcomes identified in the literature and reflected in the conceptual model include family engagement, parents' positive perceptions of the early care and education setting, family empowerment and enhanced capacity, and continuity in children's care.

***Family engagement.*** Interventions targeting effective provider facilitation of family-provider relationships have been associated with family engagement/involvement in K-12, in early care and education settings (including Head Start), and in family engagement/family support interventions. For instance, in an experimental study with 14 elementary schools, Reid, Webster-Stratton, and Hammond (2007) found that mothers who received parent training had higher school involvement than those who did not receive the training. Likewise, in a qualitative study of home visiting programs, which included focus groups and interviews with nine mothers whose children were enrolled in Early Head Start, Brookes et al. (2006) found the implementation of family-centered practices to result in increased family engagement despite barriers to participation resulting from stressors to the family and parents' individual characteristics. Similarly, in their quasi-experimental study of 275 parents enrolled in an Early Head Start program, Green, McAllister, and Tarte (2004) found that use of an empowerment approach, provider supportiveness, and cultural competence of the provider in working with families were each positively associated with families' level of engagement in services. In a quantitative research study with 171 parents, McWayne, Campos, et al. (2008) found involvement in school to be significantly associated with parents' satisfaction with school contact for both mothers and fathers.

***Positive feelings towards the early care and education arrangement/provider.*** In their review of the literature, Dempsey and Keen (2008) reported that multiple authors have found associations between family- or relationally-centered practices and parents' positive feelings or satisfaction with services for their children. Adams and Christenson's (2000) cross-sectional survey-based study of 1,234 parents and 209 teachers found parents' perceptions of the quality of the family-school interaction to be a significant predictor of both parents' trust for the teachers and teachers' trust for the parents. Similarly, using semi-structured and open-ended interviews with seven women (six mothers and one grandmother), Mensing, French, Fuller, and Kagan (2000) found parents' trust of providers to influence parents' perceptions of the quality of care provided. Finally, in a survey-based study of 164 parents within a medical rehabilitation setting, King, King, Rosenbaum, and Goffin (1999) found parental perception of the degree to which support services were family-centered to be associated with parental satisfaction of the services offered. In addition, having a positive feeling towards the early care and education arrangement/provider has been associated with both more continuity in care and greater family engagement by multiple authors (McWayne, Campos, et al., 2008; Roggman, Boyce, Cook, & Jump, 2001; Trivette, et al., 2010).

***Family empowerment and enhanced capacity.*** Relationally-oriented practices with parents, such as those described below, have been associated with families' feelings of

empowerment, both in terms of relating to early care and education staff and general feelings of self-efficacy and enhanced parent capacity. Dunst, Trivette, and Hamby (1996) conducted a quantitative study with 220 parents of preschool-aged children and found that high quality family-provider relationships, particularly those in which parents felt comfortable and autonomous, were positively associated with parents' feelings of empowerment in their choices regarding interactions with early care and education providers. Powell (1998) explained this association, stating that parents who have a positive experience with their child's early care and education teacher feel empowered to have more positive experiences with other educational staff. In Green et al.'s (2004) quasi-experimental study of families and providers from an Early Head Start program, the authors found that measures of a providers' empowerment approach, cultural competence, supportiveness, and sensitivity were each positively correlated with parents' feelings of empowerment and skills. Likewise, Dempsey et al. (2001) reviewed the literature and highlighted a positive correlation between parents' perceptions of the degree to which services were family-centered and their self-reported feelings of empowerment. Finally, in their quantitative survey-based study of 150 parents and providers, Dunst and Dempsey (2007) found that parental ratings of partnership between the family and provider were positively associated with parents' sense of empowerment. Associations between relationally-oriented practices and empowerment of families may be moderated by family characteristics. For example, Trivette, Dunst, and Hamby (1996) conducted two studies with a total of 209 parents who were involved in a family-centered early intervention/family support program targeting children with, or at risk for developing, a disability and found that lower-income families were more likely to report feeling empowered by family-centered practices than higher-income families. Though the correlation between parent capabilities and the parent-provider relationship is not yet empirically supported in the early care and education literature (Dunst & Dempsey, 2007), interventions targeted at empowering families by providing information in the health care industry have shown empowerment to be associated with increases in parents' knowledge as well as with the quality of their relationship with their children's health care providers (Hurtubise & Carpenter, 2011).

***Continuity of care.*** Parents' trust in a provider has been associated with both parents' perception of program quality and whether to keep their child enrolled in a program. In their qualitative study of 18 parents and four child care providers, DeVore and Bowers (2006) found parents who developed strong partnerships with providers were more likely to keep their children in a child care arrangement. Additionally, using data from the National Early Head Start Research and Evaluation Project, Korfmacher, Green, Spellman, and Thornburg (2007) found that, six months after the commencement of a home-based visitation program, mothers who reported more positive home-visitor relationships completed more home visits each month, had a longer period of enrollment in the program, and received higher ratings of involvement by the staff.

## **Associations between Effective Provider Facilitation of Family-Provider Relationships and Impacts on Family, Child, and Providers**

Overall, a substantial body of literature focuses on the association between effective provider facilitation of family-provider relationships and impacts on families and children. Though many of the findings reported here are based on results from experimental program evaluations and studies of interventions, some are based on other types of studies that have found associations between outcomes and parental perceptions of providers' facilitation of family-provider relationships. As discussed in the introduction to the previous section, in order to facilitate readers' correct interpretation of causal versus non-causal findings, the methodologies of studies summarized in this section are detailed. As reflected in the conceptual model, effective provider facilitation of family-provider relationships has been associated with family well-being, facilitation of families' work-life balance, positive parenting and parent-child relationships, parental connections to peer and community support; children's academic/pre-academic, cognitive, social-emotional, and health outcomes; and providers' job tenure.

### **Impacts on Families**

***Family well-being.*** A number of outcomes related to family well-being have been associated with effective provider facilitation of family-provider relationships. For example, parents' perceptions of the degree to which services are family-centered has been associated with positive outcomes related to parents' mental health, including reduced stress, emotional wellbeing, and feelings of empowerment and control in a literature review by Dempsey and Keen (2008). Likewise, Dunst and Trivette (2009) conducted a meta-analysis of fifteen medical research studies and found indirect positive effects of family-centered care practices on child and parent mental health, mediated by parents' beliefs regarding their own self-efficacy. Using experimental data from the Early Head Start Research and Evaluation Project, Chazen-Cohen et al. (2007) found impacts of Early Head Start, a program that emphasizes family-provider relationships and family empowerment, on maternal and child outcomes<sup>4</sup> when children were aged 2-3 years were associated with a decrease in maternal depression when children were 4 years old. Trivette et al. (2010) conducted a meta-analysis of eight studies and found that "capacity-building, help-giving, and family systems" (p. 14) interventions, such as those that offer supports and resources to families, focus on family strengths, and recognize family concerns and priorities, were found to directly and positively affect parent self-efficacy beliefs and parent well-being. Finally, a pre-/post-test quasi-experimental evaluation of the I-FAST intervention, a home-based mental health treatment model that focuses on building an alliance between families and providers, revealed a trend in which families engaged in the intervention became more adaptable (less rigid) and felt more competent in addressing problems that arose

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<sup>4</sup> Early Head Start impacts identified as mediators of future maternal depression included parenting distress and use of physical punishment, children's cognition and vocabulary skills, and children's aggressive behaviors.

with their children, and children were less likely to be in out-of-home placements at post-treatment compared to pre-treatment (Lee et al., 2009).

Associations have also been found between family well-being and resources provided through interventions that emphasize the family-provider relationship. For example, Guterman and Hahm (2001) studied the Parent Services Project, a center-based approach designed to provide parents with educational/activity-based supports for parenting, practical skills, leadership training, concrete assistance, recreational activities and social networking opportunities. Multiple indicators of parent/family well-being, such as increased sense of mastery and self-efficacy among parents, increased parent leadership, relationship-building skills, and a decrease in reported stress and psychological symptoms were attributed to the Parent Services Project. Specifically, Guterman and Hahm (2001) found improvements in stress, psychological symptoms, and social support to last at least 30 months post-intervention.

***Facilitation of work-life balance.*** Limited research has explored the association between provider facilitation of family-provider relationships and parents' abilities to maintain employment and experience less stress in balancing their work and family lives. Using nationally representative data from the 1990 Child Care Supply and Demand study, Hofferth and Collins (2000) found flexibility among child care providers to be negatively associated with employment exits among low-wage mothers. Likewise, based on qualitative research with 38 families, Scott, London, and Hurst (2005) stated that provider reliability and flexibility, particularly with regards to scheduling, supports low-income families' ability to maintain employment. Scott et al. (2005) found this to be especially true of families with multiple jobs, irregular and unpredictable work hours, and nontraditional shift work. Additionally, Kossek, Pichler, Meece, and Barratt (2008) interviewed 51 mother-provider pairs by phone and found social support offered to families by early care and education providers positively influenced the well-being of working parents.

***Positive parenting and parent-child relationships.*** Positive parent-child interactions, feelings of competence, and improved parenting practices have all been associated with effective provider facilitation of family-provider relationships. As described in a literature review by Dempsey and Keen (2008), interventions using the family-centered care model are positively associated with parenting competence, parents' positive judgments about their child's behavior, and parenting behavior. Likewise, in their meta-analysis of 47 studies, Dunst, Trivette, and Hamby (2007) found family-centered care interventions to have small but statistically significant associations with positive parenting practices. A qualitative study of 275 families in an Early Head Start family support program employing an empowerment approach found measures of supportiveness within family-staff relationships to be positively correlated to parenting competency and the quality of the home environment (Green, et al., 2004). As part of their pilot study of the Multi-Tiered System of Support, an intervention designed to empower children and their families through multi-dimensional support in a community-based setting, McCart, Wolf, Sweeney, and Choi (2009) conducted a qualitative study and found that more than half of the 30

participating parents reported a decrease in parenting-related stress. Likewise, in their literature review, Dawson and Berry (2002) discussed the Social Network Intervention Project, a community-based case management family support intervention, and concluded the intervention was associated with parents' improved feelings of parent adequacy, more positive attitudes about parenting, and a decrease in unrealistic expectations regarding their children. Finally, an experimental evaluation of a combined classroom and parent engagement/training intervention found this combination of services to be associated with a reduction in harsh/critical parenting and lax/permissive parenting, and increases in nurturing and attentive parenting (Reid, et al., 2007).

Indicators of positive parent-child interactions and home environments have also been identified in studies of relationally-oriented interventions. Through meta-analysis, Trivette, Dunst, and Hamby (2010) found that interventions that offer capacity-building (e.g., trainings and resource centers for teachers and administrators on family involvement) and are based on tenets of family systems theory are associated with positive parent-child interactions. Finally, a quasi-experimental study incorporating data from the Chicago Longitudinal Study found families who participated in one of the Chicago Child Parent Centers, family support centers that provided comprehensive services to low-income families to support positive parenting practices, personal development, and socialization, had lower rates of child abuse and neglect (Reynolds & Robertson, 2003).

***Parent connections to peer and community support.*** Building partnerships with families and providing opportunities for peer interaction among parents has been associated with parents' perceived ability to obtain supports and resources, according to a literature review by Dempsey and Keen (2008). Additionally, in mixed method research by Small (2009), development of social networks through early care and education settings has been associated with lower maternal material and mental hardship, particularly among mothers who are mildly but not severely depressed.

High quality, relationally-oriented interventions have also been associated with an increase in parents' social supports and connection to their peers. In a study by Guterman and Hahm (2001), the authors found an increase in social supports to be one by-product of the Parent Services Project, a center-based approach aimed to provide parents educational/activity-based supports for parenting, practical skills, leadership training, concrete assistance, recreational activities and social networking opportunities. In their meta-analysis, Dunst et al. (2007) also found family-centered help-giving practices were associated with increases in families' social supports. Finally, in a literature review by Santelli, Turnbull, Sergeant, Lerner, and Marquis (1996), the authors highlighted that programs offering opportunities for parent-to-parent networking are associated with enhanced formal and informal support networks among parents.

## **Impacts on Children**

***Cognitive development/academic performance.*** Some empirical evidence supports a positive association between effective provider facilitation of family-provider relationships and children's school readiness and academic performance. In an experimental evaluation of a Head Start intervention developed to promote parent involvement among ethnically diverse families, Mendez (2010) found program participation and the parent-teacher relationship to be correlated with higher levels of children's school readiness abilities. A quantitative study of 201 teachers by Rimm-Kaufman, Pianta, Cox, and Bradley (2003) that used survey instruments and child assessments found that teacher-reported attitudes towards family members were more predictive of children's social and academic competence than families' participation in school activities.

***Social/emotional development.*** Positive associations among interventions that incorporate elements of effective provider facilitation of family-provider relationships and children's social-emotional outcomes have also been documented. For example, in their experimental evaluation with 200 families, Roggman et al. (2009) found that children whose families participated in a home-visiting Early Head Start intervention that focused on building relationships with parents and mentoring positive parenting practices showed more attachment security than children not engaged in the Early Head Start intervention. Additionally, Sheridan et al. (2010) found children participating in the Getting Ready Intervention, designed to provide "an ecological, relationship-based approach to school readiness through collaboration" (p. 130) between families and schools, showed higher levels of attachment behaviors and a reduction in teacher-reported anxiety/withdrawal symptoms in their experimental study with 220 families. Finally, Powell et al. (2010) found parent's perception of provider responsiveness to be predictive of children's social outcomes and early reading skills, even when controlling for teacher sensitivity and the home learning environment.

Studies have also found associations between interventions that incorporate elements of effective provider facilitation of family-provider relationships and a reduction in children's behavior problems. For example, using surveys and child assessments with 117 children, Graves and Shelton (2007) found that higher levels of family-centered care in a local community mental health agency predicted lower levels of problem behaviors following one year in care. A pre-/post-test evaluation of the I-FAST intervention, a home-based mental health treatment model that focuses on building an alliance between families and providers, also showed an association between the intervention and a reduction in the severity of problem behaviors (Lee, et al., 2009). In their meta-analysis of 47 studies, Dunst et al. (2007) found participatory help-giving behaviors from the family-centered care model (e.g., individualizing practices, being flexible, meeting the needs of families, and involving families) to be more strongly associated with positive behavioral outcomes among children than relational help-giving practices (e.g., active listening, empathy, respect, and acknowledging strengths). Finally, Mendez (2010) found that, within her study of 288 predominately African-American families, high quality parent-teacher relationships, as



assessed by teachers, were associated with decreased incidence of children's problem behaviors and enhanced social competence.

**Health.** Research linking effective provider facilitation of the family-provider relationship and children's health are predominantly found in the medical literature. The family-centered care model, as applied in medical settings, is associated with better diabetes control, fewer hospitalizations, better chronic disease management, and fewer trips to the emergency room (Cooley, McAllister, Sherrieb, & Kuhlthau, 2009; McBroom & Enriquez, 2009). Only one study examining health outcomes that was not conducted in a medical setting was found. Palfrey et al.'s (2005) quasi-experimental study with 169 children found that families participating in a program that offered comprehensive services, including connecting families with resources (one indicator of high quality family provider relationships), was positively associated with the health outcomes of children when they reached young adulthood.

### **Impacts on Providers**

**Job tenure.** No research in the early care and education literature was found on the association between effective provider facilitation of family-provider relationships and provider tenure in their position or in the field of early care and education more generally. However, related research does support a positive association between effective relational practices and job tenure. Burrell et al. (2009) used a survey to study the general attachment styles of 62 home visitors and various employment-related outcomes. Burrell et al. found a negative association between having an anxious attachment style and perceptions of self-efficacy in their home visiting work and a positive association with burnout in their position. Likewise, having an avoidant attachment style was negatively associated with tenure in their position as a home visitor.

### **Associations between Intermediate Outcomes and Impacts**

As displayed in the FPRQ conceptual model, impacts of effective provider facilitation of family-provider relationships on families and children are mediated by what parents' bring to the family-provider relationship (e.g., family engagement) and other intermediate family and child outcomes. Likewise, impacts of effective facilitation of family-provider relationships on providers are mediated by intermediate provider outcomes. The review below provides an overview of empirical findings to justify the proposed mediating relationships in the conceptual model. This review is not meant to be extensive, but rather a sample of existing research findings.

### **Associations between Intermediate Family Outcomes and Family and Child Impacts**

**Family engagement in the program.** Family engagement in early care and education and other educational settings has been positively associated with children's cognitive, academic, and social skills. Early Head Start programs that engage parents in supporting children's

development have been associated with positive cognitive outcomes for children. For instance, according to an experimental evaluation by Roggman, Boyce, and Cook (2009), which included 200 families, participation in a Early Head Start home-visiting program that focused on fostering positive parent-child relationships, providing parents with information about child development, encouraging families to engage children in learning activities at home, and helping families access needed resources was associated with increased progress in children's age-appropriate cognitive skills (Roggman, et al., 2009). Additionally, in an experimental design study, Raikes et al. (2006) found that, in eleven of the seventeen programs taking part in the Early Head Start Research and Evaluation study, engaging parents in child-focused activities during Early Head Start home visits was positively associated with measures of children's cognitive and language development.

Multiple authors (Henderson & Mapp, 2002; McWayne, Hampton, Fantuzzo, Cohen, & Sekino, 2004) have associated family engagement in educational settings and promotion of learning at home with children's success in school, as well as children's social and academic skills (Henderson & Mapp, 2002; McWayne, et al., 2004). A recent study by Powell, Son, Seung-Hee, File and San Juan (2010) found, after controlling for an assessment of the home learning environment, that parent involvement in pre-kindergarten was positively associated with achievement in math and positive social skills and negatively associated with problem behaviors among children. Likewise, recent studies have linked father involvement to children's academic competence, language development, and socio-emotional skills, including children's emotional regulation (Downer, Campos, McWayne, & Gartner, 2008; Downer & Mendez, 2005). In a quasi-experimental study of 96 urban fathers and their children participating in Head Start, Fagan and Iglesias (1999) found that children's gains in academic performance aligned with the intensity of father involvement programs offered by the Head Start classrooms. Specifically, children in Head Start classrooms that offered more opportunities for fathers to be involved in recreational activities in the Head Start classroom exhibited greater gains in math scores.

***Positive feelings towards child's early care and education provider/program.*** Parents' positive feelings towards a child's early care and education provider/program have been associated with positive academic outcomes among children. Specifically, Adams and Christenson (2000) found parents' positive feelings towards a child's teacher, particularly as it relates to trust in the teacher, to be positively correlated with children's attendance in school, GPA, and standardized test score. Likewise, Hughes and Kwok (2007) examined 443 ethnically diverse first-grade students in a Texas school district and found that children displayed greater achievement gains in literacy and math from fall to spring of the kindergarten year when both children and parents reported higher quality relationships with teachers. Results from this study also found that African-American parents and children were not as likely as Hispanics and Caucasians to experience higher quality relationships with teachers (Hughes & Kwok, 2007).

***Family empowerment and enhanced capacity.*** Feelings of self-efficacy, an ability to advocate for one's child, and enhanced capacity among parents have each been associated with

positive outcomes for children and families. Kaczmarek et al. (2004) interviewed parents as part of their qualitative evaluation of the Family-Centered Preschool Model. When parents were asked how the project had specifically affected their child, all of them indicated that it had a positive effect on their children, with close to 90% noting that this effect was indirect (e.g., the program impacted parents' ability to advocate for their child, which in turn resulted in positive child outcomes). Using surveys and child assessments as part of a quantitative study, family empowerment was identified as a mediator between the family-centered care model and a reduction in children's problem behavior (Graves & Shelton, 2007). Likewise, empowering families to improve their parenting abilities has been linked to better toddler cognitive performance (Bornstein & Tamis-LeMonda, 1989), higher toddler scores on the Bayley Scale for Infant Development (Coleman & Karraker, 2003), more adaptive behavior (Coleman & Karraker, 2003), improved family cohesion (Cunningham, Henggeler, Brondino, & Pickrel, 1999), and more learning opportunities for children (Dunst, Trivette, & Hamby, 2006). Finally, Dunst and Dempsey (2007) found parents who had stronger feelings of self-efficacy reported having greater feelings of enjoyment towards parenting.

***Continuity of care.*** Most of the research addressing the associations between continuity of care and child outcomes actually documents outcomes associated with discontinuity. Longitudinal research has found that discontinuity of child care is associated with negative outcomes for children. For example, in the NICHD study, children who had experienced more day care arrangements (i.e., less stability) in the first two years of life exhibited more problem behaviors than children who had been in fewer day care arrangements (NICHD Early Child Care Research Network (ECCRN), 1998). Likewise, Harrison and Ungerer (2000) found children who had frequent changes in child care arrangements across the first six years of life exhibited more behavioral problems upon school entry than children with fewer changes in child care. Harrison and Ungerer (1997) also found discontinuity in child care arrangements to be associated with insecure attachments among one-year-old infants and their mothers.

### **Associations between Intermediate Quality Outcomes and Impacts on Children**

Multiple studies have documented a positive association between high quality early care and education practices and children's cognitive, academic, and social skills (Burchinal, Roberts, Nabors, & Bryant, 1996; Burchinal et al., 2000; Lamb, 1998; NICHD Early Child Care Research Network (ECCRN), 2006; Peisner-Feinberg et al., 2001; Peisner-Feinberg et al., 1999; Vandell, 2004). A sample of studies highlighting positive associations between high quality early care and education practices (e.g., provider sensitivity, positive emotional climate in the care setting, and effective instructional practices) and child impacts featured in the FPRQ conceptual model are provided below.

Provider sensitivity and responsiveness in early care and education settings have been significantly associated with children's attachment and cognitive development (Galinsky, Howes, & Kontos, 1995). In Pianta, LaParo, Payne, Cox, and Bradley's (2002) study of quality

in kindergarten classrooms, positive associations between teachers' positive interactions with children, classroom instructional climate, and the degree to which the classroom was child-centered were positively associated with children's social and academic outcomes, controlling for family characteristics. Howes (2000) found, in addition to other factors, the provider-child relationship and emotional climate of the preschool classroom were predictive of children's social competence with peers in early elementary school. Likewise, Kryzer, Kovan, Phillips, Domagall, & Gunnar (2007) reported that sensitive and supportive structured care environments were positively associated with children's social integration, attention/engagement, and positive mood. Finally, Hamre and Pianta (2005) found that at-risk kindergarten students who were exposed to effective instructional practices and a positive emotional climate during first grade did not differ on measures of academic outcomes compared to their lower-risk peers. Hamre and Pianta (2005) also found that those at-risk students who were exposed to effective instructional practices and a positive emotional climate in first grade scored higher on measures of academic achievement and had fewer conflicts with teachers than at-risk peers who were not exposed to a high quality first grade learning environment.

### **Associations between Intermediate Provider Outcomes and Provider Impacts**

Amongst a multitude of factors associated with provider turnover in early care and education, multiple studies have focused on three in particular: job stress, feelings towards one's position, and self-efficacy. For example, both Goelman and Guo (1998) and Todd and Deery-Schmitt (1996) found early care and education providers' negative perceptions towards their job and job stress to be related to provider turnover. In contrast, a quantitative study of 211 human service practitioners found perceived occupational accomplishments and job satisfaction to be negatively associated with job turnover (Jenaro, Flores, & Arias, 2007). Finally, Kossek et al. (2008) conducted a study with 187 family friend and neighbor providers receiving a child care subsidy and found that providers who rated the care they provided as higher quality were less likely to intend leaving their job.

### **Associations between Family and Child Impacts**

The final set of associations in the conceptual model is between family and child impacts. As with the previous section, this section does not represent a comprehensive review of the literature on associations between these components of the conceptual model. Rather, a sample of findings from empirical studies is highlighted below to justify proposed associations in the conceptual model.

#### **Family wellbeing**

The physical and emotional wellbeing of family members have been associated with positive parenting practices and positive outcomes for children. For example, Green, Furrer, and McAllister (2007) found that parents who are less anxious or ambivalent about close relationships have more frequent interactions with their children. Additionally, in their review of

the literature, Dempsey and Keen (2008) concluded that children's behavior problems are negatively associated with parental emotional well-being. Positive associations between maternal stress and depression and both negative parenting practices and negative child outcomes are also documented in the literature. For example, Jackson (2000) found parenting stress among mothers to be positively associated with behavior problems among preschool-aged children of formal welfare recipients in New York City. Lovejoy, Graczyk, O'Hare, & Neuman (2000) found maternal depression to be associated with negative maternal affect and hostile or coercive behaviors towards children by mothers. This association was particularly strong among low-income mothers and mothers with infants. Likewise, in a longitudinal study of parents with preschoolers, Hoffman, Crnic, and Baker (2006) found maternal depression to be linked to a lack of, or less effective, scaffolding of three-year-olds. Children whose mothers did not provide adequate guidance through scaffolding were less likely to regulate their emotions and more likely to exhibit problem behaviors one year later.

### **Facilitation of work-life balance**

Work-related stress has been associated with feelings of strain and overload, which is in turn associated with negative parenting practices and negative child outcomes. Crouter & Bumpus (2001) reviewed recent research on work stress and found that parents who felt overwhelmed by work stress responded to this stress by withdrawing from or engaging in conflicts with their adolescent children. These negative parenting practices were, in turn, associated with more behavior problems among adolescent children. Repetti and Wood (1997) also found evidence of work stress resulting in fewer displays of affection among parents and preschool-aged children. Likewise, Goodman, Crouter, Lanza, Cox, and Vernon-Feagans (2011) found fathers of infants employed in less supportive work environments to be more likely to exhibit a pattern of withdrawal in terms of linguistic stimulation and affective behaviors. Though the role of early care and education in mediating work-related stress has not been documented, related evidence based on perceived flexibility in the workplace (Hill, Hawkins, Ferris, & Weitzman, 2001) suggests that flexibility in the early care and education arrangement could contribute to mediating the association between work demands and maintaining work-family balance.

### **Positive parenting and parent-child relationships**

Positive parenting and parent-child relationships have been positively associated with children's social-emotional development and readiness to learn. In their empirically-based guide for early childhood practitioners, Roggman, Boyce, and Innocenti (2008) suggest that parent-child interactions influence children's social-emotional, language, and cognitive development, with parental warmth being positively associated with adjustment, compliance and school readiness and negatively associated with children's antisocial behavior. Roggman et al. (2008) specifically discuss the value of responsive interactions, parent-child play time and book reading activities, and conversations with adults in developing children's initiative, curiosity, creativity,

language and early literacy skills, and secure attachment to their caregiver. In their review of the literature, Dempsey and Keen (2008) found children's behavior problems to be associated with parental emotional well-being and parent-child activities. Additionally, in a mixed-methods study of African-American families and children, Fantuzzo, McWayne, Perry, and Childs (2004) found that children's academic motivation, attention skills, task persistence, receptive vocabulary, and problem behaviors at school were improved when parents engaged in reading with their child at home, showed an interest in what children were learning at home, and provided a space where the child could engage in educational activities.

### **Parent connections to peer and community support**

Finally, parental connections to peer and community support have been associated with feelings of self-efficacy among parents and positive parenting practices. A study among mothers of preschoolers in the U.S. and Japan found perceived peer support to be positively associated with mother's self-efficacy (Suzuki, Holloway, Yamamoto, & Mindnich, 2009). Likewise, Izzo, Weiss, Shanahan, and Rodriguez-Brown (2000) conducted a study of Mexican immigrant families and found social support to be associated with positive parenting practices. The authors hypothesized this association to result from the positive effect of social support on parents' confidence in their parenting abilities. Finally, Green, Furrer, and McAllister (2007) found mothers with more social support to be less anxious about close relationships, and consequently, more interactive with their children.

## **Section 4: Summary and Next Steps**

This review has summarized and integrated conceptual and empirical literature related to family-provider relationships. In doing so, three goals were accomplished: (1) an overview and integration of conceptual perspectives that have been used to describe and improve family-provider relationships was provided in Section 1; (2) a conceptual model that integrates unique and common elements from each of the conceptual perspectives as well as empirical literature relevant to effective provider facilitation of family-provider relationships was provided in Section 2; and (3) a review of existing evidence on the associations that are included in the conceptual model was provided in Section 3. In this final section, we will provide a summary of the literature and recommendations for future research as well as next steps for the FPRQ project.

### **Summary of Research**

**Factors Associated with Family-Provider Relationships.** Empirical evidence of associations between parent, family, and child characteristics and family's engagement in family-provider relationships was identified in this review. This research addressed each of the factors identified in the conceptual model and the findings were fairly consistent across studies. In general, engagement in family-provider relationships was negatively associated with living in

poverty, being an ethnic/racial minority, speaking a language other than English, low educational attainment, stress, mental health and substance abuse issues, restrictive work schedules, unexpected crises or stressors, perceptions that a provider is not responsive to one's needs, and low expectations for involvement among family members (Christenson, 2004; Denboba, et al., 2006; Garcia & Levin, 2001; Littell, et al., 2001; McWayne & Melzi, 2008; O'Neil, et al., 2001; Pena, 2000; Sheppard, 2002). Mothers were found to be more involved than fathers and correlates of father involvement, such as the level of satisfaction with school contact and the primary language spoken in the home, were identified (Brookes, et al., 2006; McWayne, Campos, et al., 2008; Trivette, et al., 2010). Family members' feelings of trust, self-efficacy, self-esteem, and positive feelings towards providers and social support were positively associated with family engagement in family-provider relationships and services (Gockel, et al., 2008; Reich, et al., 2004; Smith, Duffee, Steinke, Huang, & Larkin, 2008). Finally, a mixed association was found among families in which children had special needs and positive family-provider relationships, with one study finding more intensive special education services to be associated with high levels of parental trust of providers (Adams & Christenson, 1998) and another finding a positive association between children's depressed functional ability and negative parental perceptions of the family-provider relationship (Adams & Christenson, 2000; Denboba, et al., 2006).

Less research was found on characteristics of providers and family-provider relationships. Empirical evidence was found linking professional characteristics of providers (e.g., years of experience, education, and training), characteristics of the early care and education setting (e.g., type of care, funding constraints, and policies), and both positive and negative provider values and expectations towards families with the quality of family-provider relationships (Bailey, et al., 1992; Burton, 1992; Christenson, 2004; Dunst, 2002; King, et al., 2003; Knoche, et al., 2009; McBride & Rane, 2001; O'Neil, et al., 2001). No research was found on associations between providers' personal characteristics, health/mental health, or resources and family-provider relationships. Likewise, only one study was found linking community characteristics with the quality of family-provider relationships (Delgado-Gaitan, 2004).

Future research on the associations between parent, child, family, provider, and community characteristics and family-provider relationships that focuses on the specific elements of effective provider facilitation of family-provider relationships included in the proposed conceptual model could inform future professional development opportunities for providers. For example, this knowledge could be used to inform which topics are addressed in professional development initiatives targeting providers with certain characteristics. Studies on these associations should include both home-based and center-based early care and education providers so that professional development opportunities can be catered to each group.

**Associations between Elements Indicative of Effective Provider Facilitation of Family-Provider Relationships and Intermediate Outcomes.** A limited number of studies have linked effective provider facilitation of the family-provider relationship with other high

quality early care and education practices. Specifically, some positive associations between interventions targeting high quality family-provider relationships and other high quality practices were found (e.g., Haynes, et al., 1989; Webster-Stratton, et al., 2001). However, this remains an area that could benefit from further inquiry.

Evidence of associations between effective provider facilitation of family-provider relationships and provider outcomes was found in this review. Specifically, using a family systems approach, bi-directional communication, and shared goal setting and decision-making between parents and providers were associated with increases in providers' self-efficacy, competence, the development of professional goals, and ability to build partnerships with parents (Brown, et al., 2009; Trivette, et al., 2010). Family-centered care practices were also associated with increases in team development and communication with families (Kaczmarek, et al., 2004). These studies, however, are limited in their generalizability due to their reliance on primarily qualitative methods and by not including home-based child care providers in their samples.

A variety of methodologies (e.g., quantitative, qualitative, experimental, and quasi-experimental) were used in studies that documented associations between effective provider facilitation of family-provider relationships and intermediate outcomes for families and children. A bi-directional relationship was found between perceived quality of care and parents' trust of providers (Adams & Christenson, 2000; Mensing, et al., 2000). Programs that incorporate parent training, family-centered practices, an empowerment approach, supportiveness of parents, and cultural competence are associated with parental engagement and involvement (Brookes, et al., 2006; Green, et al., 2004; Reid, et al., 2007). Family-centered practices and parent involvement were, in turn, associated with parent satisfaction (King, et al., 1999; McWayne, Owsianik, Green, & Fantuzzo, 2008) and parents' perception of a positive relationship or strong partnership with providers was associated with continuity in care (DeVore & Bowers, 2006; Korfmacher, et al., 2007). Program characteristics associated with parent/family empowerment include cultural competence, sensitivity, supportiveness, an empowerment approach, emphasis on building partnerships, allowing families to feel comfortable and autonomous, and use of family-centered practices (Dempsey, et al., 2001; Dunst & Dempsey, 2007; Dunst, et al., 1996; Green, et al., 2004). Though a variety of methodologies were used, the majority of studies addressing the association between effective provider facilitation of family-provider relationships and intermediate outcomes for families and children are based on quantitative studies. Settings in which these studies took place include Early Head Start, community-based child care, and schools, in addition to medical/social service settings.

**Associations between Effective Provider Facilitation of Family-Provider Relationships and Family and Child Impacts.** Research on the associations between effective provider facilitation of family-provider relationships and family impacts is mostly based on non-experimental quantitative and qualitative studies of center-based early care and education programs (including Early Head Start), though some evidence has been found in quasi-experimental studies. Parent well-being, including reductions in parents' stress and



improvements in parents' emotional wellbeing, self-efficacy, and leadership, has been associated with family-centered practices and programs that provide supports/resources, focus on family strengths, recognize families' concerns and priorities, build an alliance with parents, and empower families through education/activity-based supports for parenting, practical skills, leadership training, and opportunities for social networking (Chazan-Cohen, et al., 2007; Dempsey & Keen, 2008; Dunst & Trivette, 2009; Guterman & Hahm, 2001; Trivette, et al., 2010). Additionally, positive family functioning (such as being more adaptable and competent when problem solving) and positive parenting practices (such as decreased harsh/critical parenting, having positive judgments about children's behavior, and being more nurturing) have been associated with programs that build an alliance between parents and providers, use family-centered practices, and focus on empowerment and support (Dawson & Berry, 2002; Dempsey & Keen, 2008; Dunst, et al., 2007; Green, et al., 2004; Lee, et al., 2009; McCart, et al., 2009). Elements of effective provider facilitation of family-provider relationships, specifically reliability, flexibility, and provision of social support, have also been associated with the facilitation of parents' work-life balance (Kossek, et al., 2008; Scott, et al., 2005). Likewise, family-centered helping, building partnerships with families, teaching parents practical and leadership skills, and providing opportunities for social networking have been associated with parents' perceived ability to obtain resources and support, and alleviation of material and emotional hardships (Dempsey & Keen, 2008; Dunst, et al., 2007; Guterman & Hahm, 2001; Santelli, et al., 1996; Small, 2009).

Research on direct and indirect associations between effective provider facilitation of family-provider relationships and child outcomes are primarily based on quasi-experimental and experimental studies. Positive academic, cognitive, and health outcomes have been associated with providing parents with information, encouraging learning opportunities at home, helping families access resources, being responsive to families' needs, family-centered practices, engaging parents in child-focused activities, and parent involvement (Cooley, et al., 2009; Fagan & Iglesias, 1999; Henderson & Mapp, 2002; Hughes & Kwok, 2007; Mendez, 2010; Palfrey, et al., 2005; Raikes, et al., 2006; Rimm-Kaufman, et al., 2003; Roggman, et al., 2009). The majority of evidence on the association between family-provider relationships and children's academic/cognitive skills is from the family engagement literature. Additionally, positive social-emotional outcomes for children have been most strongly associated with helping behaviors that are described as "participatory" by the family-centered care model. These behaviors include individualizing services, being flexible, meeting the needs of family members, involving families, and building a collaborative alliance between parents and providers (Dunst, et al., 2007; Graves & Shelton, 2007; Lee, et al., 2009; Roggman, et al., 2009; Sheridan, et al., 2010).

### **Next Steps for Research on Family-Provider Relationships**

Measurement rigor varied in the literature reviewed, with the more rigorous studies incorporating multiple modes of data collection (e.g., interviews/surveys combined with observational and/or child assessment data), multiple data points, or findings from multiple

studies (e.g., meta-analyses). Both provider and parent assessments of elements of the family-provider relationship were represented in the literature, though more studies examined parents' perspectives on the family-provider relationship than providers' perspectives. Although experimental and quasi-experimental evaluations of interventions were well represented, the majority of the reviewed studies that documented an association between elements indicative of effective provider facilitation of family-provider relationships and intermediate outcomes or impacts on providers, children, and families used quantitative, non-experimental methodologies.

This review identified numerous gaps in the literature. First, many of the experimental/quasi-experimental studies that document an association between effective provider facilitation of family-provider relationships and intermediate outcomes or impacts are based on pilot studies or evaluations of specific programs or interventions. Though broad associations between effective provider facilitation of family-provider relationships and outcomes can be identified, specific attitudes, knowledge, practices, and environmental features are frequently unspecified. This may reflect a challenge in specifying elements of intervention models that are relationally based, as relationship skills and dynamics vary greatly among individuals. Second, most of the reviewed studies used surveys to cross-sectionally assess the family-provider relationship from either the parent's or provider's perspective and, therefore, are not maximizing validity in their measures by collecting information longitudinally, through a variety of methods (e.g., survey combined with an environmental checklist), or from multiple respondents. A third gap in knowledge addresses what family-provider relationship dynamics happen in the absence of interventions. Though some studies describe the relationships early care and education providers have with families (Adams, et al., 2008; Bromer, 2005; Bromer & Henly, 2009; White, 2002), most of these studies are qualitative and based on small samples. There is no research documenting what is happening in the absence of intervention or relationally targeted programming with a nationally representative sample of providers. Finally, though research on Head Start and Early Head Start is well represented in this review, there are fewer studies on other types of early care and education, particularly home-based child care settings.

Though some measures were used in multiple studies, there does not appear to be one measure that is used to assess effective provider facilitation of family-provider relationships across disciplines or across early care and education settings. Measures used to assess constructs indicative of effective provider facilitation of family-provider relationships in the literature tend to be either aligned to a specific construct of interest (e.g., Trust Scale [Adams & Christenson, 1998]; the Parent and Caregiver Perceptions of Communication Questionnaires [Ghazvini & Readdick, 1994]) or designed specifically to assess constructs from one of the conceptual perspectives in Section 1 of this review. For example, multiple measures assess parent involvement/family engagement, including the Family Involvement Questionnaire (Fantuzzo, Tighe, & Childs, 2000), Parent and Teacher Involvement Measure (Conduct Problems Prevention Research Group, 1995), and Family Participation Measure (Friesen, 2001; Friesen & Pullman, 2002). Others are focused on the family-centered care perspective, such as the Family-

Centered Practices Scale (Dunst & Trivette, 2006), the Helpgiving Practices Scale (Trivette & Dunst, 1994), and the Medical Home Index (Cooley, McAllister, Sherrieb, & Clark, 2003).<sup>5</sup> Because existing measures focus on a specific conceptual perspective, no measures were found to capture all of the elements of effective provider facilitation of family-provider relationships detailed in the proposed FPRQ conceptual model.

### **Next Steps for the FPRQ Project**

In conclusion, this review has found support for the proposed conceptual model of family-provider relationships. However, it has also identified gaps in the literature that would benefit from further research. One such gap is the lack of a measure of effective provider facilitation of family-provider relationships that incorporates all of the elements posited in the FPRQ conceptual model (see Section 2) and is applicable across early care and education settings. To fill this gap, the FPRQ project will develop a new measure.

The conceptual model and literature review presented in this document constitute the first in a series of steps towards this goal. Specifically, the constructs and elements identified in the “Effective Provider Facilitation of Family-Provider Relationships” box of the conceptual model has served as the framework for identifying and writing items for the new measure. In addition, the conceptual model and review of the empirical literature was used to identify potential intermediate outcomes and impacts that could be used to indicate predictive validity of the instrument(s). Finally, in completing the empirical review, measures used in the literature to assess effective provider facilitation of the family-provider relationship were identified, which contributed to the second step in the process of developing the FPRQ measure, described below.

The second step in the process of developing the FPRQ measure was to conduct a thorough review of existing measures that assess elements listed in the “Effective Provider Facilitation of Family-Provider Relationships” box of the conceptual model (see Porter et al., under review). The measures review served as the foundation for identifying both gaps in current measures and promising items.

As there is relatively sparse literature on parents’ and providers’ perceptions of high quality family-provider relationships, the third step in the process of developing the FPRQ measure entailed conducting focus groups with early care and education providers as well as parents in order to further explore a number of topics. Focus group topics included assessment of (1) the most important characteristics of a high quality family-provider relationship from parents’ and providers’ perspectives; (2) the extent to which the proposed conceptual model fits with parents’ and providers’ experiences and perceptions; (3) whether and how family-provider relationships benefit families, providers, and children; and (4) factors that influence family-provider relationships (e.g., age of child, race/ethnicity of family/provider). Focus groups were also used to explore terms that parents and providers use when they are discussing the elements

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<sup>5</sup> For more information about measures of family-provider relationships, see Porter et al. (under review).

in the conceptual model and the applicability of elements across providers and parents with different characteristics.

Based on results from the focus groups and the measure/item review, a draft measure was developed. The fourth step in the measure development process is the testing of this draft measure through cognitive interviews with parents and early care and education providers. After feedback from the cognitive interviews is used to develop a second draft of the measure, it will be psychometrically tested through a pilot test, then revised again and, lastly, tested in a larger field test.

For additional products from the Family Provider Relationship Quality project, please visit [http://www.acf.hhs.gov/programs/opre/other\\_resrch/fprq/index.html](http://www.acf.hhs.gov/programs/opre/other_resrch/fprq/index.html).

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## Appendix 1:

### Technical Work Group for the Family-Provider Relationship Quality Project

Catherine Ayoub, Ed.D.  
*Harvard University*

Carl Dunst, Ph.D.  
*Orelena Hawks Puckett Institute*

Julia Henly, Ph.D.  
*University of Chicago*

Judith Jerald  
*Save the Children*

M. Elena Lopez, Ph.D.  
*Harvard Family Research Project*

Julia Mendez, Ph.D.  
*University of North Carolina at  
Greensboro*

Douglas Powell, Ph.D.  
*Purdue University*

Lori Roggman, Ph.D.  
*Utah State University*

Suzanne Randolph, Ph.D.  
*University of Maryland*