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The development of the Promoting First Relationships home visiting program and caregivers' comments about their experiences across four RCT studies

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Abstract
Promoting First Relationships (PFR) is an evidence-based home-visiting program for caregivers and their children from birth to age 5 years. It focuses on caregiver–child interaction, attachment, and relationship quality using video feedback of unedited recordings to elicit reflection and provide positive feedback linked to knowledge development. This paper provides a brief history of PFR and reports on a qualitative study of 222 caregivers' comments about their PFR experiences following participation in one of four randomized controlled trials conducted over the past decade in the United States (two studies within child welfare setting, one study with Native American families, and one study with Spanish and English-speaking mothers), using a thematic analysis approach to code excerpts from written satisfaction surveys and oral satisfaction interviews. Caregivers' comments about PFR were positive and were classified into four major thematic areas: a caring, trusting relationship with the provider; enthusiastic program endorsement; improved relationship with their child; and reports of their personal growth and development. The qualitative results align with the key components of the PFR program and confirm aspects of the PFR theory of change model.

KEYWORDS
home visiting, intervention, qualitative study, strengths-based, video-feedback

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1 | THE DEVELOPMENT OF THE PROMOTING FIRST RELATIONSHIPS HOME VISITING PROGRAM AND CAREGIVERS' COMMENTS ABOUT THEIR EXPERIENCES ACROSS FOUR RCT STUDIES

Promoting First Relationships (PFR; Kelly et al., 2003, Kelly, Sandoval, Zuckerman, et al., 2008, 2016, 2025) is a 10-week evidence-based, home-visiting program for caregivers and their children aged birth to 5 years. It is also a training program for early childhood service providers to infuse infant mental health approaches into their practice. Five randomized control trials (RCTs) have evaluated the program. Two trials were conducted with child welfare populations (Oxford et al., 2016; Spieker et al., 2012), two with rural Native communities (Booth-LaForce et al., 2020, 2022), and one with Spanish and English-speaking new mothers who had received prenatal mental health referrals from community health clinics (Oxford et al., 2021). Three additional RCTs are currently being conducted (Oxford, 2017, 2023; Oxford et al., 2024).

Across all five completed studies, PFR improved observed caregiver sensitive and responsive care and caregiver knowledge of social and emotional development (Booth-LaForce et al., 2020, 2022; Oxford et al., 2016, 2021; Spieker et al., 2012). PFR also improved a range of child behavioral/emotional outcomes (Oxford et al., 2016, 2021; Pasalich et al., 2016), child stress physiology (Hastings et al., 2018; Nelson & Spieker, 2013) and social attention in children at risk for autism spectrum disorder (Jones et al., 2017). In one child welfare study, toddlers in the PFR group had 2.5 times fewer out-of-home placements 1-year post intervention than those in the comparison group (Oxford et al., 2016). In another child welfare study, more toddlers in foster and kin placements experienced stability in their placement with the caregiver who received PFR compared to the toddlers in the comparison group (Spieker et al., 2014) up to 2 years after the intervention.

PFR has consistently demonstrated high fidelity and participant satisfaction (Booth-LaForce et al., 2023; Lohr et al., 2023; Oxford et al., 2018), and high dosage and retention (Lohr et al., 2023; Oxford et al., 2018). In a postintervention focus group, study participants in a Native community indicated a strong appreciation for the PFR providers' positive engagement and compassion and reported experiencing personal growth as well as improved caregiver–child relationships (O'Leary et al., 2022).

This manuscript reports on the development of PFR, its significant elements, and the results of a qualitative analysis of 222 responses to an open-ended question across four samples, which included families identified by child protective services (Oxford et al., 2016), a perinatal mental health sample of mothers and their infants (Oxford et al., 2021), families in a Native community (Booth-LaForce et al., 2022), and a child welfare sample of reunified birth parents (Oxford et al., 2017).

Key Findings

- Participants providing feedback about their experiences with Promoting First Relationships report positive evaluations of the home visiting model, with 97% providing explicit positive endorsements.
- Participants' comments were clustered under four interconnected themes: caregiver indicated they had a positive relationship with their provider; they appreciated the program; they experienced benefits to their relationship with their child; and they experienced personal growth because of the program.
- Participants spontaneously identified that the experience of receiving video feedback was positive and that it helped them understand their child better.

Relevance

This study explores caregivers' experiences with an evidence-based home visiting model that incorporates video feedback, strengths-based methods, and reflective engagement strategies. Gaining insight into caregivers' perspectives on this model highlights their lived experiences and the value they find in this approach. The findings offer guidance to the field on implementing strengths-based and reflective strategies across diverse populations.

1.1 | PFR theory of change

PFR is based on attachment theory and relationship-based supportive approaches that emerged in the fields of infant psychiatry (Fraiberg et al., 1975) and infant mental health (Osofsky & Fitzgerald, 2000; Zeanah, 1993, 2000) in the decades after Bowlby's first volume on attachment was published (1969). It is explicitly strengths-based. Attachment-based programs are considered effective for improving caregiver–child relation-

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ships (Bakermans-Kranenburg et al., 2003; Fernandes-Alcantara, 2018). PFR focuses on the dyadic interaction between caregiver and child using video feedback. Specifically, PFR uses unedited video recordings of caregiver–child interaction in reflective observation sessions. The PFR program grew out of Dr. Jean Kelly's dissertation (Kelly, 1979, 1982) in which she designed a program to promote parent–child interaction quality for children aged birth to 3 years with developmental disabilities. In the 1970s, early childhood intervention was compensatory and directed at remediating lags or deficits in young children's development. Programs were typically designed to educate parents to "teach" their infants and toddlers. Parental coaching and modeling were common strategies to help parents promote children's development. Dr. Kelly, mentored by Dr. Kathryn Barnard (Barnard & Neal, 1977) and influenced by the work of Ainsworth & Bell (1975), Brazelton et al. (1974), Beckwith (1972), Bromwich (1976), Robson and Moss (1970), Stern (1974) and later by Hirshberg (1996), Lieberman (1997), Pawl (1995), Pawl and Saint John (1998), and Sroufe et al. (1993), realized that the intervention field needed to prioritize the parent–child relationship which is foundational to child growth and development. She designed her dissertation as an intervention study to promote the quality of the parent–child relationship and used positive feedback and videotaped interactions to significantly increase the positive and noncontrolling behaviors of parents with infants with disabilities. The early dissertation work using engagement strategies and videotaped interactions became the basis of the first edition of the PFR Curriculum for Service Providers (Kelly et al., 2003). Prior to the initiation of the RCTs, several smaller studies refined the PFR training program for early childhood service providers and examined outcomes for participating providers and families (Kelly et al., 2000, Kelly, Sandoval, Zuckerman, et al., 2008).

PFR trains service providers to center the parent/caregiver–child relationship, even when the focus of intervention is the child's developmental challenges. PFR supports the idea that the *parent/caregiver is the expert*, as well as the belief that caregivers' confidence and competence increase through strengths-based strategies (Kelly et al., 2003, Kelly, Zuckerman, & Rosenblatt, 2008, 2016, 2025) asserted that change would occur when caregivers could observe and reflect on their relationship with their *unique* child. Observation and reflection create an avenue for caregivers to explore the meaning of their child's behavior and the ways in which behavior reflects the child's underlying social and emotional needs. The video recordings of caregiver–child interactions provide a space to explore their unique relationship and offer positive support and joint reflection on the developing relationship. Unedited video recordings enable the PFR provider and caregiver to focus on both the joys and the struggles of caregiving. The video-recorded interactions are not always smooth, allowing the caregiver to explore difficult moments as well as positive ones with a nonjudgmental, reflective provider.

PFR-trained providers use specific consultation strategies throughout their interactions with families during each session:

1. *Joining* questions and behaviors promote a trusting relationship with the parent. The provider builds rapport by entering the world of the caregiver and child, encouraging the caregiver to reflect on their own and their child's world.
2. *Positive instructive feedback during live or video observation* are when the provider pauses and makes a positive comment to the caregiver and specifically identifies how their behaviors support their child's social and emotional development. Positive and instructive feedback builds caregiver confidence and competence.
3. *Reflective questions and comments during live or video observation* are when the provider pauses and asks the caregiver about their child's feelings or needs or about their (the caregiver's) feelings and needs. Reflective questions promote both caregiver self-knowledge and knowledge about their child's development of trust, security, and emotional needs.
4. *Handouts and activities* support caregivers' understanding of their own and their child's emotions and needs.

PFR providers typically video record 10–15 min of the caregiver and child interacting (play, teaching, or caregiving tasks). On alternating weeks, the provider and caregiver watch the recording together during *reflective observation*. Providers are trained to identify places to pause the video and engage the caregiver using the PFR consultation strategies of positive instructive feedback and reflective questions and comments (see Kelly et al., 2016; Oxford et al., 2018). Reflective observation is used to both increase the caregivers' awareness of the importance of their interactions with the child, and the quality of the dyadic relationship. During reflective observation the provider uses the consultation strategies, and the caregiver is invited to comment and discuss the interaction. For example, providers may use positive instructive feedback, identifying how the caregiver is meeting their child's need and how this supports their child's development. Providers might say, "I noticed that when your child was getting upset and turned away, you followed her cue and let her take a break to calm down. This lets her know that you are in touch with how she is feeling and that you will wait for her to show you when she is ready to play again." When the interaction is more challenging, providers are

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trained to pause the video and ask open-ended, nonleading questions related to the child's feelings or needs or the caregivers' feelings or needs. In other words, to adopt a *wondering* stance. For example, a provider might say "What do you think your child was feeling when she arched her back?" The caregiver responds with their own reflections and insights. The PFR guidance for feedback is central to the PFR strengths-based strategy. Providers are trained to focus on: What is the caregiver feeling? What is the caregiver needing? What is the child feeling? What is the child needing? How can the caregiver meet their own and their child's needs?

Underlying the PFR program design and training is the *parallel process* (Davis et al., 2021; Kennedy et al., 2017; Tomlin et al., 2016). A common concept in the field of infant and early childhood mental health, the parallel process denotes that interaction in one part of a system reinforces interactions in other parts of the system, as when a service provider is supported in reflective supervision and is able, in turn, to be attuned to caregivers, who, feeling supported and valued, can respond sensitively to their infants.

PFR is rooted in attachment theory, which postulates that children need access to a caregiver that comforts and protects the child and that the child's sense of security provided by the caregiver is optimal for growth and development (Bowlby, 1988). In a parallel process, the service provider, caregiver, and child all develop skills from a secure base:

> We [providers] pay attention to how we are in relationships with caregivers so that they feel known, understood, accepted and responded to. We strive to help caregivers feel safe enough to be themselves and safe enough to open themselves up to growth and change. Our relationships with caregivers give them the opportunity for *felt* empathy and *felt* security. Once this security in the relationship is established, we, as providers, can help caregivers begin to understand and accept their own feelings, as well as the feelings and needs of their young children. (Kelly et al., 2016, p. 22).

A sense of safety and security within a relationship allows the individual (whether it is the supervisor, provider, caregiver, or child) to engage in the process (whether that is supervision, a home visit, or observation), become curious, and explore their thoughts and feelings as well as the thoughts and feelings of those they are within that moment. Without a sense of safety and security, interactive partners will be less open, less reflective, less flexible, and less likely to gain insights from the interaction. The PFR program extends the parallel process to providers. PFR trains supervisors and consultants to provide reflective consultation to providers using a PFR framework in which supervisors and consultants maintain a *wondering stance* with the provider and ask what the provider is feeling and what the provider is needing. Using PFR strengths-based and reflective strategies during supervision and consultation increases the providers' sense of safety in the supervisor-provider relationship, which enhances their reflective capacity and insight in interaction with caregivers.

PFR explicitly centers the caregiver–child relationship and views the caregiver as the expert on their child. Kelly (1982) and Kelly et al. (2016) noted that social service providers are often siloed and focus on either the child's needs (e.g., providers who work directly with the child in which the caregiver is an observer), or on the caregivers' needs. Even when service providers are focused on parenting and the dyad, they may inadvertently threaten caregivers' sense of competence and confidence by taking an expert stance by directing the parent how to care for their child. A more directive strategy also runs the risk of overriding culturally derived parenting practices, rather than encouraging reflective exploration of practices that may or may not fit the parents' current circumstances or hopes for their child. By centering the caregiver–child relationship and adopting a positively focused *wondering* stance, caregivers are given the opportunity to safely explore their own parenting practices as well as their child's needs within the context that they are parenting.

This approach makes PFR very adaptable to multiple settings, cultures, and experiences of caregivers. PFR's adaptability is supported by consistent significant results across all five completed randomized trials using different types of community-based providers (bachelor- or masters-prepared), caregivers (birth fathers and mothers, kin, and foster care providers), ages (newborn to 5 years), languages (Spanish and English), settings (perinatal mental health, child welfare, community services), and communities (metropolitan, suburban, and rural Native).

1.2 | Purpose of the present study

In this study, we conducted a qualitative analysis of responses to a request for comments about PFR from caregivers who completed the PFR program within four RCTs. The aim of this study is to understand caregiver perceptions and experiences receiving PFR, providing a level of insight not available through quantitative data (Kane et al., 2007). In our past work we reported on quantitative implementation outcomes: quality/fidelity, dosage, and

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parental satisfaction (Booth-LaForce et al., 2023; Oxford et al., 2018). However, more can be learned from caregivers' perceptions and experiences that might provide insight into "mechanisms of change" (Butler et al., 2020). This question goes beyond identifying barriers and facilitators to enrollment (e.g., see Koerting et al., 2013; Reardon et al., 2017) or predictors of retention (Jester et al., 2023). Rather, the question here is *how* do parents or other caregivers experience the program? What can we learn from caregivers' first-hand experiences, and what insights might be generated to understand how the program works to generate the reported outcomes (Holtrop et al., 2014). Specifically, we examine whether the caregivers' experiences of the program reflect the premises and goals of PFR.

2 | METHOD

The analysis combined qualitative data from 222 participants who completed PFR in four RCTs conducted between 2010 and 2020. All four studies were designed prospectively to capture caregivers' satisfaction with the PFR program with an 11-item survey; 10 items were scored on a Likert scale, and one item was open-ended. For the open-ended item, participants provided either written responses to the satisfaction survey that they returned in the mail (2 studies, $n = 129$), or oral responses in a recorded telephone interview (2 studies, $n = 93$). In the studies with written responses, the providers gave the participants a satisfaction questionnaire with a stamped return envelope at the final PFR visit and instructed participants to complete the survey and mail it to the research office. PFR providers told the parents that they would not see their surveys. In the studies with respondent satisfaction collected by telephone, at the end of the final PFR visit the providers informed the parents that a research coordinator would call them within the next day and ask a few questions. The researcher coordinator was not a PFR provider and had no direct contact with participants. The research coordinator was trained to deliver the scripted interview in a neutral tone. The participants were informed that their comments would not be shared with their PFR providers, and they were encouraged to be open and honest about their feelings. In both oral and written formats, after rating their satisfaction and experience with the PFR program, participants responded to one open-ended, nonleading question: "Do you have any additional comments about the program?" In the oral interviews, if the participant had a brief reply, the research coordinator was instructed to paraphrase their responses and then prompt, "Can you tell me more?"

2.1 | Sample

Table 1 describes the four studies and the participants providing written or oral responses to the request for comments on PFR. The main-effects papers and clinical trials information cited at the bottom of Table 1 provide additional detail on the study samples. Two studies were from a child welfare population (Supporting Parents Program denoted as SPP and Families Together denoted as FT), one study from a North American Tribe (Tribal Study denoted as TS), and one study with a sample that included both Spanish and English speakers (perinatal mental health denoted as, PMH).

2.2 | Analytic Approach

This paper utilized a thematic analysis approach guided by the influential methodology developed by Braun and Clarke (2006, 2022). The lead data analyst is not a member of the research or provider teams or the PFR program. She worked with two members of the research team to form an analysis team. This three-member analysis team worked collaboratively with the larger study team, which included principal investigators from each of the PFR studies, the director of the PFR Program, and the site coordinator and PFR provider from the Native study to construct a primarily deductive set of codes informed by initial reviews of the data. Neither the analysis team nor the larger study team included the program developer, Dr. Jean Kelly. The analysis team developed the initial codes and presented them to the larger study team, codes were subsequently refined during the initial coding process and approved by the study team. The codes were refined and grouped into potential themes through an iterative process. The analyst used codes to organize the data for analysis and theme development. The first dataset was dual-coded by the three-member analysis team to ensure reliability and agreement on the theme application. The analysis team carefully reviewed and refined these themes and worked collaboratively with the larger study team, referring to the original data to ensure accuracy and coherence. Credibility and trustworthiness of the analysis were prioritized throughout the study process, which involved sharing methodological approaches and initial results back with the larger study team for internal review. A robust audit trail documented all decisions made during the analysis process. Triangulation was achieved across data, analysts, and the lived experience-based expertise of the PFR director and a PFR provider on one of the studies. The study team reached consensus on the final themes and sub-themes most reflective (in terms of frequency and/or

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TABLE 1 The four RCT samples contributing participant comments about PFR.

	Study name			
	Supporting Parents Program (SPP)	Perinatal mental health (PMH)	Tribal Study (TS)	Families together (FT)
Population	Open CPS investigation of child 10–24 months	Prenatal mental health referral; Infant under 2 months; preferred language Spanish or English	Caregiver of child 10 months–3 years who were Tribal members on or near the reservation	Pre-COVID sample of birth parent and child 1–5 years, reunified in trial return home status at enrollment
Study enrollment period	2011–2014	2015–2021	2017–2018	2018–2020
Study *N*	247	252	161	144
N randomized to PFR	124	127	81	74
N Completed PFR	107 (86%)	104 (82%)	41 (51%)	45 (61%)
N Completed comments on PFR	84 (78%)	62 (60%)	40 (98%)	43 (96%)
Type of data	Written response returned via mail	Written response returned via mail	Recorded phone interview	Recorded phone interview
Main effects papers	Oxford et al. (2016)	Oxford et al. (2021)	Booth-LaForce et al. (2023)	Oxford (2017)
Clinical trials registration # and principal investigator	NCT01332851 (Oxford)	NCT02724774 (Spieker)	NCT02139332 (Booth-LaForce, Oxford, Buchwald)	NCT04382677 (Oxford)

Abbreviations: PFR, Promoting First Relationships; RCT, randomized control trials.

salience) of participant experiences with the intervention. Each study contributed to the results.

3 | RESULTS

In a sample of 222 participants who received PFR across four studies there were 1024 codes applied to qualitative responses to the open-ended question. An overwhelming majority of PFR participants reported a positive experience in the program, $n = 217$ (97%).

We first analyzed whether the total number of codes varied by the method of data collection. Phone interviews were conducted for the FT study and the TS study. In FT, 322 codes were assigned to the 53 respondents, averaging 6.1 codable items per respondent. In the TS study, 264 codes were assigned to the 40 respondents, averaging 6.6 codable items per respondent. The two paper/pencil studies had a lower overall number of codable comments, as would be expected due to the written nature of the data collection tool. In the SPP study, 67 participants submitted written comments that resulted in 209 codes, on average 3.1 codable items per respondent. In the PMH study, 62 participants provided written comments that accounted for 229 codes, averaging 3.7 codes per participant. Scrambled ID numbers are provided in the results that indicate which study the comment came from; in the PMH study the ID number is followed by an E for an English speaker or S for a Spanish speaker. This analysis showed that the phone interviews provided a greater number of responses, were lengthier overall, and went into more depth, which will be reflected below in the qualitative results.

Four primary themes were identified and were evident across all four samples. These themes are interconnected, with the most common theme being the caregiver's report of having a caring, trusting, and positive relationship with their provider. The second theme was the caregiver's explicit praise of the program. The third theme was the caregiver's reported benefits to their relationship with their child, and the fourth theme was the caregiver identifying a personal change such as gaining insight into their parenting behavior or emotions around parenting and gaining confidence. Because video feedback is a unique and key component of PFR, we report caregivers' comments on this experience.

We also identified a meta-category we labeled *learning and growth*. This category was created during the coding process. We label this a meta-category rather than a theme because it reflects the inter-connectedness of the prior four themes, which emerged mostly from phone interview comments that clearly demonstrated the way in which the four themes were connected. In the meta-category, respondents identified in very clear ways how they grew through the positive experience with the program or provider, and what elements of the program were most meaningful to their growth. This category reflects the ways in which caregivers thought about their own personal, unique journey over the course of the program. For ease of interpretation,

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TABLE 2 Exemplars for phrases and comments coded within each theme.

Theme	Proportion of sample ($N = 222$)	Exemplar 1	Exemplar 2	Exemplar 3
Provider positive, caring, trusting	63%	“she (provider) is just so awesome.”	“(provider) in general is very, very lovely, warm and kind individual.”	“she (provider) treated me with more respect.”
Positive program endorsement	62%	“It (PFR) was amazing.”	“I greatly thankful with all the people who have made this program possible.”	“The program was great. I would do it again.”
Benefits to the caregiver–child relationship	38%	“I learned more about his attachment to me and our relationship together.”	“I guess overall, little exercises more or less ways to strengthen our relationship and develop more dependability on me and trust.”	“I think this program help build my relationship with my child for the better.”
Personal benefits to the caregiver	19%	“This was the most awesome eye opening experience ever, and I learned a lot not only about me but also about the way I raise my kids.”	“It just gave me a boost of confidence with my parenting.”	“It honestly helped me really well. It determined what I was frustrated with.”
		Exemplar 1	Exemplar 2	Exemplar 3
Meta category	27%	“Feedback about the program, I guess at times I thought I wasn’t a good enough parent. That [PFR] reassured me on things and how I was doing, it helped me understand my son’s cues and needs. I get it now! I get him! I want to think about him in a different way. It helped me to step back, take a breath, evaluate the situation and understand the situation, why is he acting this way? Is he scared? Is he stressed? Does he need me? It makes it a little more comforting in the situation–and for him, he is more happy and secure, knowing that mom gets what I’m saying or why I’m acting this way. I get him now.”	“Overall, it was really good, because I learned so much. I learned stuff that I just didn’t know. I just had babysat when I was younger for my sisters and stuff. Everything was, all the information, was spot on…how to better handle really difficult situations…how to better be a more supportive father for my daughter, different ways to get on her level. Everything was really good, very informative.”	“It was new to me and my son. My son is two yrs old, and you know, everything I learned—I’ve put, whenever I do met with her, I learned something new all the time. I do, like the steps for ’working your kid’ that the behavior, feelings, needs, you know, I go through those steps and I do find them of use. You know, with me and my son’s relationships and I’m very close with my son. And I have a bond, I mean, any mother has a bond with her child. But putting it in a positive way, is going to reflect on how they feel out there. I feel the program–I learned a lot from the program and I would recommend it to a lot of people.”

Abbreviation: PFR, Promoting First Relationships.

Table 2 provides a summary of the proportion of participants whose comments were coded relevant to each theme with corresponding exemplars.

3.1 | Theme 1: Positive, caring, trusting relationship with provider

The theme of a positive relationship with the provider was explicitly mentioned by 139 (63%) participants. There were five sub-categories in this theme: (a) sense of trust/safety/comfort with the provider, (b) feelings that the provider was kind and warm, (c) feeling respected, (d) feelings of being seen/heard/ and listened to, and (e) feelings of being reassured/validated.

Trust and feeling safe or comfortable are essential to the relationship building process and frequently co-occurred alongside program endorsements (program endorsements co-occurred in 70% of instances when trust was mentioned) and other positive provider relationship qualities.

These trusting provider-caregiver relationships are supported by specific salient qualities that caregivers

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described. The provider-caregiver relationship was often characterized as trusting and being able to share their feelings or needs with their provider (e.g., “I felt very open and able to talk with her.” PMH1692E):

> [Provider] is frick’n amazing! She is super attentive and she is super sweet. She worked really well with my son. There are just no words, she is just so awesome. It sucks that I can’t continue on the relationship. It’s like a trusting friendship that we kind of built. It is a good program, you know, I learned a lot. A lot I already knew, but I incorporated it with the program. I have communication issues, I guess I could say. So I have more issues on how to explain it. I grew up from a PTSD background, 33 years of it or something. The way I grew up we didn’t communicate this way, very well. So I guess now I have better words to put to things. FT2515

> I was very skeptical about the whole study at first. I have never been able to have strangers in my home so close to my family. This was the most awesome eye-opening experience ever, and I learned a lot not only about me but also about the way I raise my kids. The way I am, I felt that I and [provider] touched and reached a past side of me that I locked a long time ago, and it helped me understand and repair a lot of things in my present and probably in my future. I loved the program. PMH1333E

> I would say that the staff and the [PFR provider] was very open was very willing to help me understand and umm, I felt comfortable to express my concerns and needs and questions I had about my parenting and my child. I personally recommend it to anybody who really, really, really wants to try and grow and connect with their child. TS1492

Other caregivers described the qualities that the provider demonstrated such as being kind, warm, sincere, or respectful:

> The [Provider] in general is a very, very lovely, warm and kind individual. I really, really liked working with her and really appreciated the time she spent with my child and me and also the time she spent with just me explaining how the program worked and new parenting techniques. FT2500

> This program really does help me and my kids. I love the way my provider [PROVIDER] being kindly to us. She’s the best provider I’ve ever been counseling with. SPP1746

> I really learned a lot. Firstly my provider was the kindest most understanding and flexible woman ever. She made this experience as a whole more enjoyable while still teaching me everything I needed to know. I am very pleased. PMH1643E

> She always listened to me & my child’s needs.:) She was great. I have done lots of programs throughout the last 2 years. She treated me with more respect & listened to me & my family. I feel very good! SPP16502

> I thought this was a great program and that [provider] did a great job…and I felt that she was very sincere with me and my family. SPP1365

Consistent with the idea of feeling respected, some caregivers described feeling seen, understood, and listened to:

> It, it was—I didn’t know what to expect but I really appreciated that she listened and that we could talk as, not just as a professional, but I felt comfortable with her. The program was frick’n awesome! FT2510

> I loved the information, the visits, and how much they listened to me. PMH1284S

> [Provider name] was super amazing! This program help me express my feeling and feel understood which cause less stress and feel more reveal of my emotions. Great program! PMH1895E

> It was very understanding and helped me through a lot. I really enjoyed the program and sad to be done with it. SPP1173

Caregivers also described feeling cared for or supported:

> [Provider] was extremely caring towards our emotions. Our family learned a lot on how to cope with the kids emotions. It’s amazing how this program can have one on one interaction with the families and hope that more fam-

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ilies will be able to receive this opportunity that we got. Thank you so much for everything [Provider] has done for us!!! Thanks from [NAMES] SPP1802

[Provider name] was very supportive through this whole process and I felt like both my child and my needs were met. Overall, this was a wonderful experience for both of us! PMH1515E

[Provider name] has been such an incredible support for my child and I. Her warm and compassionate attitude along with her resources has helped me thru this rough patch in my life. Thank you so much! PMH1235E

I liked the program–I thought it was very helpful. It was very insightful. The lady I worked with [PFR provider] she was extremely nice and she was very caring… TS1407

PFR is a lot different then what I learned in [the CPS] parenting class. Parenting class was just, like, disciplinary and PFR is like, a needs based program. When [Child] came home, she was really not doing well, she was having a really hard time with the transition, so that's why I asked for PFR from my social worker–cause it was just, the return home was not going well and I was having a hard time dealing with it. So um, now that I have completed the program—things are 100% or 180 degree turn around. FT2507

The strengths-based PFR approach supported caregivers' trust in the program and the provider. In the quote below a parent explains how they appreciated the reassurance and validation of their strengths and relates that feeling to enjoying the PFR program and appreciating the provider. Some caregivers reflected that acknowledging their strengths opened areas for improvement.

I loved the program and my provider–I have already referred people I know. I'm just thankful I had the opportunity to be in the program and I think it's a wonderful thing for mothers that are getting their children back [reunification after foster care]. The kind of support I felt and when we re-watched the play activities with videos, I think it is really cool how you guys have us, you know, watch and point out the good things we are doing. I think my confidence in parenting has gone up 100% and I'm just really thankful and super happy I got to be part of it. FT2514

I loved this program. I feel like it really did help in more than a few ways. It taught me what I doing right and what I could work on. She is an amazing person and I really liked working with her! PMH1311E

I thought it was a great experience. [PFR Provider] was really amazing! Me and my daughter are really going to miss [PFR Provider]. She made me feel really validated and made a lot of my insecurities as a parent go away. FT2566

[The PFR specialist] was very well versed, to pointing things out to me and I appreciate that so much. She would always say, "well look now, you are actually teaching him things by what you are doing!" and I thought, "really?" [caregiver laughs] You know, I wasn't thinking of it like that. I was just playing with him, but then I could see he was learning so much from how I was playing with him. I guess, I never would never have looked at things like that. She was very easy to talk to and understood where I was coming from, being such an elderly person and all. TS1417

3.2 | Theme 2: Positive program endorsement

The second most dominant theme was explicit positive and enthusiastic program endorsement, with 138 (62%) participants spontaneously endorsing the program. While these comments were often brief (e.g., "It was amazing. It was helpful. It was insightful. I wish I could do more. I would recommend it to any parent. I liked it, and we can talk about this for hours." FT2568; "It was great, and wish it was something I could continue" SPP13601; "I liked the program a lot; I would like other people to get it." PMH1572S), the majority of comments were followed with reasons for the strong endorsement, which often included an overlay of other themes such as endorsement of the provider (e.g., "It is one of the best programs I have been to, I feel very satisfied and grateful to [provider name]" PMH1445S). Other respondents provided a deeper description about why they liked the program, for example:

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> Um… It was, I mean… At first, I was hesitant with how it was going to go, but the program was, it was really nice. I've been to a couple of parenting classes at this point. It definitely doesn't compare to this, this just added this extra help that I needed and the kind of motivation to not only maintain a healthy lifestyle with my son, but for myself, it made [me] feel cared about as a mother and not everyone worrying about what I am doing for my son. FT2578

> I would not change anything about the program. It helps me a lot to have someone else outside of my home to talk to and have someone who can relate to me. My children and I adore those quality times together and it makes me realize most things that I don't see myself doing on a daily basis. There was more to learn and some things were new to me. I love the fact that I get to see/watch videos of "bonding" time w/my children and see who/how I interact w/them. Thanks so much! SPP1063

> I greatly thankful with all the people who have made this program possible; It helped me a lot in my role as mom, to know more about my child's needs. Thank you. PMH1773S

> This program was great. I'd do it again. It helped immensely and I truly feel my provider listened and helped with understanding the communication between me and my [child]. Thank you sooo very much. SPP1601

3.3 | Theme 3: Benefits in the caregiver–child relationship

The third theme identified was participants noting that the program improved their relationship with their child, which was explicitly and spontaneously stated by 84 (38%) participants; 62% of the comments came from those who had a phone interview, suggesting when parents were able to share verbally their experience, they went into more depth on how the program impacted their relationship with their child. Aspects of caregiver-reported benefits to the caregiver–child relationship were highlighted as especially meaningful and include: (a) noticing and understanding their child's perspective, cues, or behavior, (b) having a stronger emotional connection or bond to the child, and (c) feeling they have improved communication with their child. What stands out in some of the comments is that caregivers clearly gained reflective capacity: parents learned to pause and consider their child's social and emotional needs, they gained a deeper understanding of their child's behavior through reflection and understanding their child's social and emotional needs, and this deeper understanding is reflected in relaying a sense of improved connection, bond, or relationship. One explicit PFR strategy is that providers ask open-ended reflective questions about what the caregiver believes the child is feeling or needs. These first set of quotes reflect the multilayered ways parents learn about their child's needs in a new way and how this growth had a positive impact on their relationship with their child.

3.3.1 | Greater understanding of child's perspective

> When I first started the program.... I thought, "Oh gosh, okay great just another program to keep an eye on me, right?" But then I started it and then the first couple visits I was like, "Wow this is awesome!" It got me getting to know a little bit more about my child. It just opened my eyes little bit better on getting to know, to notice his feelings and how he needed to express himself as well. I learned more about his attachment to me and our relationship together. It just helped me understand my child about him trying to let me know what he wanted to say, even though he couldn't use his voice yet. FT2522

> I felt it was a very informative and educational, as far as telling me things that my kid needed that I never thought about. I feel like it really opened my eyes about how I needed to be more empathetic to the things that he has gone through, instead of being offended by things–like the way he would act out. You know, I would take it a different way now that I have done this program. I feel that I'm really able to realize what lead up to that and maybe what he is lacking that is making him feel a need to have the behaviors. I feel that I got a lot of really good feedback with my videotapes, I am very observant and when I play with him I am really tuned in with my child. I think it was nice to have that reassurance. I really enjoyed my visits with [PFR Provider], I think she was really great and she just gave me good

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ideas and I really appreciate it. It was a good experience. FT2503

It helped me, it helped me a lot with dealing with my daughter again. She is a very emotionally high-strung kid and it really helped me address some of her behaviors and correlating them to her needs. I got a lot from my time with [PFR provider], it really helped me with my relationship with my daughter. FT2522

…We definitely enjoyed it. I really like how it focuses on understanding the social emotional needs of the kid. You know, I thought it was really important because it helps you get down to the bottom of the issues instead of just reacting. I thought that was really important. FT2518

I think this program help build my relationship with my child for the better. It has help me understand him more as a child. I am glad I did this program. SPP1627

I loved the information, the visits, and how much they listened to me. This program has changed me for the better and in how to recognize better my baby's needs. Thanks. PMH1284S

The program, Promoting First Relationships, it was really a great experience. It helped me understand more about my child, my daughter, and that she is still growing herself and she is still learning to understand her emotions. Figuring out that they are always going to need us, but they are going to want to explore and be independent themselves and that every kid is different and they are born different. It's really opening me up more, you know, about learning different ways to handle and cope with her emotions as well as mine, and I just thought it was overall a really great experience, especially for any new parents, or new moms or single moms or single parents. [PFR Specialist] was awesome. TS1415

3.3.2 | Stronger emotional bond

The improved sense of bonding or connection was also clearly stated. Caregivers drew the connection between getting to understand or know their child and their child's feelings and needs, resulting in an increased bonding or emotional connection.

The program got me a lot closer to my son. It showed me emotions that I did not think he would have, our bond together is closer than it was before and I feel like through the program I got to be with my son, a lot more than just being his mom. I feel like, I'm his best friend now, and I know what he wants and needs. TS1503

It helped me just like, reconnecting with my son, because he was away from me from a long time so I had to kind of like, catch up with really knowing him. I think it also helped with my daughter, even though she is not in the age range that it was for, but I think it really applied to her too. FT2517

Well, I felt that the program really helped my relationship with my daughter. You know, get more close to her. It seems that I am really there for my daughter now, when she feels upset and I know how to deal with her when she is having a bad day. TS1648

I believe this program is very interesting because I learned things I did not know. Although I have more children now I feel more connected with my baby because I learned tips that I ignored and thought it was not important. Thank you very much for helping me relate more with my baby! PMH1324S

Oh, man! It was great! I learned a lot about different skills to use as far as, you know, taming my little monster [laughs] yah, I mean ways we can defuse situations better. I guess understand where he's at with his thoughts and feelings. I guess overall, little exercises more or less ways to strengthen our relationship and develop more dependability on me and trust. FT2502

3.3.3 | Improved communication

Here caregivers use the term "communication" to reflect a better understanding of their child's nonverbal language, recognizing that children are "talking" through their cues and behavior.

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> Was a very fun way to learn about the needs of my baby, we enjoyed seeing our person every week. She was amazing and incredibly caring. I learned a lot and feel like I have the best communication with my son! PMH1716E

> I'm kind of sad that it ended, when we got involved with this program, me and my son, we needed it, we needed help with our communication–we needed it bad. I just didn't have nowhere to turn, no resources, no help. So it couldn't have been a better time to have gotten involved. I think it's a great program, I think that everybody needs to be taught how to communicate better with their children. TS1446

> I've learned that the social and emotional needs are very important to me because it's like if my baby or my kids are speaking to me, and now I pay more attention to those needs and cues. Thank you! PMH1713E

3.4 | Theme 4: Personal benefits to the caregiver

Theme four represents comments in which the caregiver described personal change, for example, gaining insight, confidence, or better emotional understanding; 42 (19%) caregivers spontaneously identified ways in which the program benefited them by gaining insight into the reasons they feel or parent the way they do. Some parents reported that they gained a sense of confidence, while others noted a benefit in their own emotional understanding. More than half, $n = 22$, of the comments came from the FT study with reunified birth parents. Embedded in these comments are elements of the PFR intervention that focuses on the provider asking the caregiver to reflect on *their* underlying feelings and needs.

One parent commented on the increased ability to pause and reflect on how certain child behaviors made the caregiver feel, which was something new for the caregiver to consider:

> I guess I gained a lot from the program. [PFR provider] was super sweet and knowledgeable. …She pointed out "how did that make you feel?" And I never asked myself that. Now I can think and take a breath… The 12 weeks went by fast and it was too bad that it ended. My family benefited, and [PFR provider] gave great advice and great ideas on how to reflect on things and listen and give kids the time to think too. FT2559

Related, some caregivers identified that they had more insight into how they parented and why they struggle and how they might cope.

> …This was the most awesome eye opening experience ever, and I learned a lot not only about me but also about the way I raise my kids. The way I am, I felt that I and [provider] touched and reached a past side of me that I locked a long time ago and it helped me understand and repair a lot of things in my present and probably in my future. I loved the program. PMH1333E

> It just gave me more perspective of what I am doing. It reiterating some of the positives that reoccurring and showing me how to deal with some of the negative things as well. It's a good insight for those that are struggling, it gives them more information and tools to work with. FT25354

> The program was really helpful it helped me realize that there is a connection—a physical and emotional connection between a mom and a child. That, the program does help with steps that help you get past the barrier that you don't know the solution or…and the steps to take to overcome it. It really did help. TS1745

Several caregivers identified gaining a sense of confidence. This is an important construct from the growth mindset that is explicitly a part of the PFR program.

> The program was really helpful. Not just for future help, but by helping me open my eyes to what I was already doing and pointing out things that I was doing really well in. It just gave me a boost of confidence with my parenting. TS1508

> I loved the program and my provider–I have already referred people I know. I'm just thankful I had the opportunity to be in the program and I think it's a wonderful thing for mothers that are getting their children back. The kind of support I felt and when we re-watched the play activities with videos, I think it is really

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> cool how you guys have us, you know, watch and point out the good things we are doing. I think my confidence in parenting has gone up 100% and I'm just really thankful and super happy I got to be part of it. FT2514

Caregivers also commented on how their own emotional capacity was supported by gaining the ability to notice and name their own emotions.

> I thought it was really helpful. It gave me an opportunity to really understand the feelings behind my son's actions and what he was doing. It honestly helped me really well. It determined what I was frustrated with and what I needed to focus on with him. I would definitely encourage other parents to use this program. FT2570

> [Provider name] was super amazing! This program help me express my feeling and feel understood which cause less stress and feel more reveal of my emotions. Great program! PMH1895E

3.5 | Meta-category of learning and growth

As noted earlier, there was a distinct embeddedness of the themes reflected in comments that included positive provider or program endorsement, with specific reference to learning about oneself as a parent or one's child. Caregivers spontaneously connected multiple aspects of the PFR logic model, that is, the fact that PFR providers use strengths-based strategies and the parallel process to support the caregiver's sense of safety and trust which enables them to explore their own parenting and reflect on the underlying needs of their child. The quotes in this category fully demonstrate the multifaceted active ingredients in the PFR intervention theory of change. There were 59 (27%) participants that reflected the meta-category of learning and growth. Many of the comments that were coded *Learning and Growth* are already listed above to represent individual themes. A few more potent examples not already noted are provided below.

The following quote represents all of the elements of the PFR Program: The caregiver notes that they have more insight into their behaviors as a parent, they increased their comfort/confidence, they learned how *their* child communicated nonverbally, and they learned how to take the child's perspective, especially with regard to safety and security, an attachment construct, which resulted in a deeper understating of their child's social and emotional needs.

> It was really cool. Learning little cues. Learning a lot of different things about being a parent. I think, ultimately before doing it I didn't feel I was a parent and I didn't know what I was doing. Now I definitely know. It's still frustrating but I definitely have enough knowledge, I know a lot more, am a lot more comfortable. .... Probably some of the biggest thing is the cues, I don't know if it's because it's still fresh on my mind. I knew, there are the obvious ones, like if he's crying or if he has a frown, throwing a fit. But it's the little ones that I had no idea, the little subtle cues like touching, being close. I don't know any of that stuff. So that is pretty interesting. I like how [the PFR provider] always try to get you to think of it from the child's perspective, safety and security, giving it meaning. It makes understanding kids' issues easier to take apart. FT2538

The caregivers similarly shared the multifaceted way the program impacted them. They reported increasing confidence, greater understanding of their child's needs and cues, and a deep desire to pause, reflect and wonder about his experience and his needs as a way to help him feel safe and secure.

> Feedback about the program, I guess at times I thought I wasn't a good enough parent. That [PFR] reassured me on things and how I was doing, it helped me understand my son's cues and needs. I get it now! I get him! I want to think about him in a different way. It helped me to step back, take a breath, evaluate the situation and understand the situation, why is he acting this way? Is he scared? Is he stressed? Does he need me? It makes it a little more comforting in the situation–and for him, he is more happy and secure, knowing that mom gets what I'm saying or why I'm acting this way. I get him now. FT2526

3.6 | Video feedback

We were interested in what caregivers would spontaneously say about the video feedback process. Of the 18 comments on the video feedback process, 100% were positive. Participants reflected on the way in which video

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feedback supported their ability to pause, reflect, and observe.

> I really liked it. I think what I got out of it the most was being able to watch the videos with my provider and just being able to notice different cues with [daughter]. I found it interesting to catch when, maybe, her behavior changed or her body language changed and umm, and just being able to see how I interacted with her was pretty interesting… FT2521

> I really loved it, because it helped with me and my son's relationship. What they talked about [the topics]—I then noticed all of that. Just like the videos, where she recorded us and we watch them back, I really liked the video part. Seeing us play and learning new things. I really liked the program. TS1718

> The videos help me step 'outside' the moment & gives me a chance to see room for improvement. SPP1048

> …Before I never really noticed that as I was not really observing my child's behaviors, the video feedback really helped with that. It was a good program and helped me communicate with my kids better. FT2505

4 DISCUSSION

The results of this qualitative study indicate that PFR is a positive and insightful experience for caregivers and their children. There was overwhelming endorsement of the program and providers. We believe this is largely due to the emphasis on the parallel process and the provider's training to center and value the caregiver's expertise, experiences, and needs. PFR strategies, which are based on attachment theory and infant mental health values, acknowledge the critical importance of feeling psychologically safe in order to explore and learn. A sense of safety is crucial for the parents, children, and providers. It is through feeling safe and cared for that the individual (parent, child, or provider) can be more flexible, open to reflect on feelings and needs, and willing to explore, learn, and practice new ways of parenting.

What is most compelling about the results of this study is that caregivers spontaneously identified key components of the PFR program. They identified having a greater understanding of their child's social and emotional needs and noted that they had learned about their child's nonverbal communication and were making the connection between their child's behavior and their social and emotional needs. Caregivers spontaneously said they had a deeper understanding of their child which translated into a stronger bond. They shared the desire to be more reflective and ask themselves the reflective questions that the PFR provider would ask, and to pause and take a moment to reflect on the meaning of their child's behavior. Caregivers made a connection between their increased understanding of themselves or their child, and their increased sense of confidence and competence. One of the comments from the FT study of reunified parents perfectly summarized the PFR theory of change:

> … I get it now! I get him! I want to think about him in a different way. It helped me to step back, take a breath, evaluate the situation and understand the situation, why is he acting this way? Is he scared? Is he stressed? Does he need me? It makes it a little more comforting in the situation–and for him, he is more happy and secure, knowing that mom gets what I'm saying or why I'm acting this way. I get him now. FT2526

The results of this study also confirm aspects of the PFR Theory of Change Model and is relevant to understanding previous quantitative results. Across all completed RCT studies, PFR improved caregiver-sensitive and responsive caregiving behavior and caregiver knowledge of social and emotional development. The result of this qualitative study *provides evidence of how* PFR produced the quantitative findings. Caregivers became more attuned, more observant, and more responsive because they had a positive experience with a provider with whom they felt comfortable and safe. Within the provider–caregiver relationship, and through the support of strengths-based video feedback, caregivers were given the opportunity to explore *their relationship with their child*, to pause, observe, reflect, discuss, and practice. We believe that using video feedback is central to the PFR model of change as it allows caregivers the time and space to explore and observe. A variety of video feedback approaches have been shown to be effective in improving caregiver–child interactions (Alves et al., 2024; Fukkink, 2008; Kennedy et al., 2017; Rusconi-Serpa et al., 2009). Some approaches use preselected segments of a video recorded observation to facilitate a specific conversation, often around reciprocal interactions (Dozier & Bernard, 2019; Fisher et al., 2016) while others use video recording in a sequential-structured manner to scaffold caregivers' learning process (Juffer et al., 2018). PFR may be unique compared to other programs because providers

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record caregivers and their children interacting for 10 to 15 min, the recording is played back, unedited, during the following visit (after the provider has had an opportunity to review). Attachment Video Feedback Intervention Program (AVI) also uses unedited video recordings, like PFR, however, providers record the interaction and play the recording back during the same session (Moss et al., 2018). Programs also differ on how providers are trained to use video recordings. Some programs use the videos to coach caregivers on how to interact or respond to their child while other programs use a more reflective approach that avoids coaching. What is consistent across programs is that caregivers are given positive feedback for the skills that they bring to the interaction.

From a precision home visiting perspective (Haroz et al., 2019, 2020; Supplee & Duggan, 2019), we believe that the PFR approach, which weaves reflective consultation strategies with joint observation of an unedited video recording, is one of the main "active ingredients" of the program. When PFR first became a training model in the early 2000s, some providers and agency leaders were concerned that the video recording aspect of the program would be a barrier because caregivers would not feel comfortable or safe doing the recording. While some individuals may feel uncomfortable with video recording (O'Leary et al., 2022), we have found video recording is an excellent strategy to support caregivers' reflective capacity, and the qualitative results support its acceptability to caregivers. The use of video recordings with observation, feedback and reflection has proven to be an effective strategy for the caregiver to learn about and understand *their* child's experience or perspective, and then adapt their parenting accordingly. It is not abstract, and the observations are personalized to each unique dyad, so they hold greater weight in the learning process. The video recordings also allow for the caregiver to pause, reflect, and practice that reflection multiple times throughout the program.

The results of this study are relevant for PFR and may not reflect caregivers' experiences with other home-visiting programs. Future research examining how participants' experiences link to the goals of other home-visiting programs could advance the field and improve home-visiting services (Holtrop et al., 2014). It is also worth noting that the qualitative results from this study reflect comments from only those who completed the PFR program. Attrition ranged from a high of 49% in the TS study to 14% in the SPP study (see Table 1). However, we have focus group data that informs our understanding of TS participants who did not complete PFR (O'Leary et al., 2022). We engaged both those who completed PFR ($N = 11$) and those who did not ($N = 6$). The themes of the completer group reflect similar themes from this study including appreciation for the program and providers, personal growth for the caregiver, and improved caregiver–child relationships (O'Leary et al., 2022). For those who did not complete the program, three participants commented: one indicated they were too busy, one indicated their house was too crowded to do home visits, and one indicated that the structure of the visit was not consistent with their parenting strategy. We are continuing to investigate and address PFR noncompletion. For example, in our current RCT with parents involved in child protective services, we are comparing PFR by telehealth to PFR by home visiting. We are interviewing noncompleters in both groups, in a systematic manner, to enhance our understanding of the concerns or challenges caregivers face with engaging in the intervention.

4.1 | Conclusion

PFR began as a dissertation project (Kelly, 1979, 1982) aiming to understand how service providers could support the caregiver–child relationship in the process of addressing the developmental challenges of infants and toddlers. After years of training early intervention providers, nurse home visitors, and childcare providers, Kelly (2003) published the first edition of the PFR curriculum manual. Quasi-experimental studies and publicly funded service provider training projects further enhanced PFR consultation and intervention. Eight RCTs have been initiated in diverse communities of families with children from birth to 5 years of age. The most recent RCT (Oxford et al., 2023) will test PFR effectiveness in child welfare using a telehealth model for PFR delivery developed out of necessity during the COVID-19 pandemic. In addition, a PFR training model for pediatric primary care providers was developed (Kelly et al., 2013) and is disseminated nationally.

These research, training, and program adaptations show that PFR is an effective and flexible service delivery model for caregivers of children birth to five. The results of this qualitative study of caregivers' experiences of PFR deepen our appreciation for the power of reflective observation and strengths-based consultation strategies to help caregivers from different populations experience personal growth and deeper connections with their children. Results also support relying on video feedback of unedited caregiver–child interaction recordings as a potent opportunity to apply these reflective consultation strategies. Finally, as our research program progressed over the last 15 years, we found that collecting feedback though an oral interview was preferable to a written response as it allowed us to have a deeper understanding of the program impact. Qualitative research that reflects participant experiences will help the field identify and operationalize

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effective home visiting strategies and provide critical links to program theory of change.

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