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Reaching Isolated New Mothers: Insights From a Home Visiting Program Using Paraprofessionals

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ABSTRACT

The Visiting Moms Program delivers a relationship-based home visiting intervention in which volunteers address challenges faced by at-risk new mothers and families. For new mothers experiencing isolation, anxiety about parenting, lack of support, or limited resources, this program offers a volunteer, who is a mother herself, in the role of a mentor mother to connect the new mother to resources, listen without judgment, and strengthen parenting abilities. Less stress for the mother and improved care for the infant are major program goals. Relational theories and studies on home visiting interventions are used as lenses for viewing this type of intervention. Vignettes are included to deepen our understanding of the mechanisms through which the new mothers change. Clinicians, program planners, and administrators are likely to find this article helpful in its coverage of the literature on volunteers and home-based services, its description of the relational intervention provided by one home visiting program using volunteers, and its recommendations for ways in which others can design such programs.

> The new mother needs and wants to be "held," valued, appreciated, aided, and given structure by a benign, more experienced woman who is unequivocally on her side. (Stern, 1995, p. 183)

Daniel Stern, an internationally recognized expert in the study of parent–infant relationships, poignantly captures the essence of the new mother's psychic condition. He also portrays the premise underlying the process and outcomes of a volunteer home visiting intervention described here. Since its inception in 1989, the Visiting Moms Program has provided direct supportive home-based services to at-risk new mothers and families in a major metropolitan area in the northeastern United States. Aware of the challenges facing new mothers, the program uses volunteer paraprofessionals from the local community to visit new mothers in their homes. Unlike many home visiting interventions, this one is not only psychoeducational or curriculum focused. Instead, the volunteer paraprofessionals, trained by the agency from a particular theoretical vantage point and armed with the basic skills of helping familiar to most social workers, provide a consistent, supportive relationship tailored to each client that combats the isolation characterizing the lives of so many new mothers (Paris & Dubus, 2005). Subscribing to the contemporary relational theories of Stern (1995), Slade (2002), and Jordan, Kaplan, Miller, Stiver, and Surrey (1991), the agency administrators and clinicians have consciously structured the program to reflect a parallel process in which supervisors demonstrate the behavior in their relationships with volunteers that they want the volunteers to develop with the new mothers.

This article is written with clinicians, program planners, and administrators in mind. Initially, we discuss the empirical literature on the postpartum experience, theoretical models for understanding early motherhood, and what the field knows about home-based interventions for at-risk mothers and families. Then we use the Visiting Moms Program as an example of how such interventions can be implemented, hoping to stimulate readers to develop or participate in such programs. Two case vignettes show key elements of the volunteer–new mother relationship. The conclusion specifies implications for practice. With this study, we remind clinicians of the value of relational theories in viewing both mother–infant relationships and intergenerational relationships and clarify for clinicians key internal processes experienced by their postpartum clients. For program planners and administrators, we spell out the advantages of using volunteers as service providers for high-risk groups such as the new mothers described here.

Postpartum Experiences of Isolation and Loss of Family Support Networks

Early motherhood is characterized by a remarkable series of transitions and transformations that begin in earnest during a woman's first pregnancy (Cohen & Slade, 2000; Stern, 1995). Both research and clinical literature provide substantial discussions of the factors that affect the transition to parenthood and subsequent parenting. Belsky (1984), a prominent psychologist and contributor to the field, identified, in his seminal writing, three primary determinants of parenting: the personal characteristics of the parent, the child's characteristics, and the contextual sources of support. Cowan, Cowan, Heming, and Miller (1991) offer additional variables that affect the transition to parenthood, including the quality of the parents' relationship, the quality of the parent–child relationship, intergenerational factors, and the relationships between family members and individuals and groups outside the family.

For women, the complexity of this transition can be further intensified with the experience of mood changes commonly known as the postpartum blues. An estimated 26% to 85% of new mothers are identified as suffering from these difficulties (O'Hara, 1994). Women may describe feeling sad, emotionally unstable, anxious, or lonely. At the more severe end of the spectrum, postpartum depression is estimated to occur in 15% of women who give birth (Murray & Cooper, 1997; O'Hara, Zekoski, Phillips, & Wright, 1990). New mothers encountering the mood shifts described previously are challenged in their early parenting, which places them and their children at risk of attachment difficulties among other problems (Weinberg & Tronick, 1998).

In sociological and historical terms, new mothers have traditionally benefited from a supportive matrix of other women such as grandmothers, aunts, midwives, and a woman's own mother. Kin networks have been described as facilitating satisfied mothering by providing both concrete practical support and equally critical emotional support (Fischer, 1983; Mitchell & Green, 2002; Stern, 1995). The importance of available nuclear and extended family is also borne out in research literature indicating that, with the birth of a child, women frequently become emotionally closer with their own mothers and female family members (Cowan et al., 1991; Fischer, 1983; Mitchell & Green, 2002; Stern, 1995). Indeed, the absence of one's own mother during the postpartum period has proven to be a prevalent theme among the new mothers participating in the Visiting Moms Program (Paris & Dubus, 2005). We posit that these kinship systems are increasingly unavailable in present-day life, and their absence resounds in the postpartum experiences of new mothers.

In a society in which women are often geographically removed from their own mothers and female family members, technological modes of communication such as e-mail and the telephone serve as poor or limited substitutes for the physical proximity of their own families. Having a substitute supportive system is often essential for new mothers to adapt to the many emotional, psychological, social, and physical changes confronting them.

Existing supportive relationships are subject to vast changes as a woman adapts to her role as a new mother. For example, change in the marital relationship frequently occurs with the transition to parenthood (Cowan & Cowan, 2000; Cowan et al., 1991) and is often concurrent with a perceived decline in partner support (Cowan & Cowan, 2000). Likewise, changes in the mother's relationship with her own mother are common (Cohen & Slade, 2000; Fischer, 1983; Mitchell & Green, 2002; Stern, 1995). As previously noted, female kin relationships often undergo a strengthening with the birth of a child. Alternatively, however, they can become more fragile (Fischer, 1983). With the transition to parenthood, new mothers may also find themselves socially isolated and experiencing an unfamiliar tenuousness in previous social relationships as time constraints grow and common interests diverge.

These experiences of feeling isolated during early motherhood compound the everyday stresses inherent in a society in which supportive family is less geographically accessible. Experiences of loneliness and isolation, which are widespread in postpartum populations, are well documented (Cowan & Cowan, 2000; McGuigan, Katzev, & Pratt, 2003; Richards, 1977; Taggart, Short, & Barclay, 2000). Rearing a child in one's grandmother's or mother's generation was significantly different from rearing a child today. Even if kin are available and provide advice, the new mother may feel at a loss for what to do because both the common wisdom and professional guidance on child

rearing have changed significantly over these generations. This is true even on issues as basic as whether to put the infant to sleep on his or her front or back. In many cultures, the older generations were less likely to work outside the home while rearing children, so new mothers who have been in the workforce may view their older relatives as out of touch with the realities of modern family life. Hence, both geographic and psychological distance may operate in making new mothers feel even more isolated.

Intensive interviews with 15 first-time mothers in an urban area who were participants in a home visiting program provide substantive evidence of the primacy of isolation in the lives of some new mothers (Paris & Dubus, 2005). The experience of loneliness and isolation from friends or co-workers can prevail even in mothers who live in close physical proximity to their family members (Mitchell & Green, 2002). The prevalence of isolation is particularly important because it is a risk factor for child abuse and neglect (Moncher, 1995; Polansky, 1985; Schmid, 1990).

Relational Theories and Their Illumination of Early Mothering Experiences

The theories discussed in this section are connected by their central focus on relationships for understanding human growth and behavior. Stern (1995), Slade (2002), and relational–cultural theory (RCT) proponents such as Jordan et al. (1991) place relational growth at the center of their theoretical frameworks. Each does this in a somewhat unique way, but all offer contributions to our understanding of the mothering process and the needs of women as they transition to the new role of caregiver.

The Visiting Moms Program was created to strengthen families by helping them from the time of their earliest parenting experience. By supporting mothers in their adjustment to a new biological or adopted infant, the program seeks to foster healthy nurturing relationships and reduce the risk of child abuse and neglect. In contrast to other programs that address the need for correcting behavior or treating dysfunctions, this program aims to prevent parenting difficulties and develop and strengthen maternal capabilities. As a primary prevention initiative, the program aims to destigmatize supportive services in the transition to parenting. It operates under the assumption that positive change can take place in the context of a supportive nonjudgmental mentoring relationship. The program philosophy, based on the works of Stern (1995), Slade (2002), and RCT proponents (Jordan et al., 1991), focuses on the idea that one needs to feel nurtured in order to nurture another. Hence, the volunteer's work centers on the mother's needs in order to further her ability to care for her infant. Program goals follow this assumption and philosophy by striving to have the home visiting volunteer develop an effective caring relationship with the new mother, which increases self-esteem and feelings of self-confidence. In this relationship, the volunteer is taught to be available and empathic toward the new mother so that, in turn, the mother may be available and empathic toward her infant. The new mother's connection with the volunteer is the first step in reducing isolation and helping the mother learn to trust herself.

Given that isolation, psychological and social stressors, limited understanding of child development, and poor parenting skills are some of the known predictors of child abuse and neglect (Gomby, Culcross, & Behrman, 1999), the volunteer home visitor works to ameliorate these challenges through her ongoing relationship with the new mother. Specifically, the visits with the volunteer initially serve to break the loneliness. Eventually, the focus on encouraging the new mother to try other community resources, such as support groups, expands her connections. Offers of concrete and emotional support diminish psychological and social stressors. As the volunteer and new mother build their relationship, they often observe the infant together. The volunteer will frequently offer comments about the infant's behavior with the intention of making the new mother aware of typical steps in child development. Additionally, the volunteer will hear out the new mother's parenting concerns or misattributions about the infant. Through shared problem-solving strategies or guidance, the mother's parenting skills are improved.

The New Mother's Concerns, Challenges, and Preoccupations

Coining the term motherhood constellation, Stern (1995) captures the essence of the external and internal reorganization of a woman's psychological and emotional reactions that occur with the birth of a first child. Stern argues that, with the birth of a child, many Western women enter a psychic realm unlike any other that they will encounter. This constellation of issues, thoughts, feelings, and behaviors inevitably requires that the mother attend to specific challenges and concerns such as reflecting on her relationship with her own mother, developing her self-concept as a mother, and developing a relationship with her infant. As described earlier, the importance of a new mother's own mother has also been identified by others as a primary element in the transition to motherhood (Cohen & Slade, 2000; Fischer, 1983; Slade & Cohen, 1996) not only in terms of the new mother's current relationship with her mother but her reflections on their past relationship as well.

Stern (1995) proposes that the new mother is preoccupied with questions regarding her child's life and growth and her own ability to connect authentically to her infant and provide a supportive matrix or network of caring individuals for them both. These concerns will surface for the mother through emotions, which can include fear, worry, sadness, and loneliness.

The New Mother's Mastery of the Skill of Imagining the Infant's Mental States

New mothers may also experience differing levels of skill in their ability to imagine their infant's mental states and experiences, which is a necessary component in meeting a young infant's needs and desires (Slade, 2002, 2003). A mother's ability to draw effectively from her own experiences while imagining, understanding, and responding appropriately to her infant's mental states is referred to as parental reflective functioning. When it is impaired, as it for many clients of the Visiting Moms Program, a mother may fail to meet her child's needs or may misinterpret his or her behaviors (Slade, 2002, 2003).

The New Mother's Need for Role Models

RCT posits that an individual's psychological development occurs in the context of growth-fostering connections through the experience of being heard, seen, and understood (Jordan, 1997; Jordan et al., 1991; Miller & Stiver, 1997). The lens of RCT aids our understanding of the benefits of, and need for, role models and a supportive matrix to sustain the new mother through the transition to parenting (Slade, 2002, 2003; Slade & Cohen, 1996; Spielman, 2002; Stern, 1995). With the experience of being cared for, supported, and nurtured through these changes, the woman can be freed to care for her infant. Without such nurturing connections, a woman may experience a loneliness that minimizes her sense of personal worth and causes her to withdraw from relationships (Jordan & Hartling, 2002; Miller & Stiver, 1997). When services provide the fundamental connections with supportive others that RCT deems so necessary for human growth, new feelings of self-worth, empowerment, and desire for relationship can be created in the new mother.

Methods Used by the Paraprofessional Volunteers to Respond to the New Mother's Emerging Developmental Needs

The Visiting Moms Program uses the theories of Stern and Slade as well as RCT to provide an intervention in which isolated and at-risk new mothers are offered an authentic relationship with a mentor paraprofessional volunteer, who can form the core of the supportive matrix crucial during the first year of parenting. A requirement for paraprofessional volunteers is that they have also had children; thus, they are mothers themselves and have had parenting experience. This paraprofessional volunteer is available to hear the new mother's own developmental challenges as well as her fears and concerns for her baby. Using the woman-to-woman relationship as the primary tool for growth and change, the paraprofessional volunteer helps to develop the reflective function capacities of the new mother so that she can feel more confident in her mothering skills and, ultimately, more authentically connected to her baby. The volunteers participate in specialized training in the skills of helping (described later) as well as group supervision, which facilitates their implementation of the intervention with empathy and consistency.

Findings From Home Visiting Studies: What Works?

A number of volunteer paraprofessional home visiting programs in the United States and abroad target vulnerable families. Vulnerable families are those that may be headed by first-time, single, or teenage parents; be geographically or socially isolated, socioeconomically disadvantaged, or struggling with depression; or have high family conflict (Black & Kemp, 2004). In many of the home visiting interventions described in the literature, the nature of the relationship between the mother (most often the main program participant) and the volunteer is the very foundation of the program's process, progress, and success (Black & Kemp, 2004; Hiatt, Michalek, & Younge, 2000; Paris & Dubus, 2005; Taggart et al., 2000). Through the established relationship, volunteers in these various programs provide emotional and practical support, education, role modeling, and companionship for the mother. They may also help her to initiate other activities such as participation in mothers' groups, play groups, and community functions. To summarize this literature, together the mother and volunteer engage in a reciprocal relationship that benefits each individual in unique ways. Evaluation data show that both volunteers and mothers consistently indicate a high level of satisfaction through the home visiting experience, and mothers and families have benefited (Black & Kemp, 2004). The reciprocity in these relationships, and the participants' emphasis on this as a valuable outcome for them, makes the programs that use volunteers stand apart from other home visiting programs that use paid or professional staff (Duggan et al., 2004; McDonald Culp et al., 2004; Olds et al., 1999). Thus, a major difference between the two types of programs is in the nature and reported quality of the mother–service provider relationship.

It should be noted that there is a difference of opinion in the human services field about whether paraprofessional home visitors are optimal service providers (Gomby et al., 1999; Hiatt, Sampson, & Baird, 1997; Olds et al., 2002, 2004; Sweet & Applebaum, 2004). Studies examining the effects of nurses compared with paraprofessionals as home visitors have indicated that initially nurses' interventions provided significant positive outcomes that were absent from, or minimal for, groups of families visited by paraprofessionals (Olds et al., 2002). These positive nurse-visited client effects include both maternal and child health, development, and life course outcomes. However, further investigation into the differential benefits of nurse-delivered versus paraprofessional-delivered interventions has yielded new findings. Notably,

a late 2004 study of postprogram follow-ups showed positive effects on mothers visited by paraprofessionals (Olds et al., 2004). Within this study, women began to benefit from the paraprofessional visitation in important, unique ways 2 years after the program ended. Mothers home visited by paraprofessionals reported a greater sense of mastery and improved mental health than did mothers home visited by professionals.

Among home visiting studies not yet cited, there are additional programs that also indicate the potential strengths and benefits of using paraprofessional home visitors, whether paid or volunteer (Black & Kemp, 2004; Hiatt et al., 2000; Taggart et al., 2000). For example, because paraprofessionals frequently belong to the community in which they conduct their visits, which is often not true of their home visiting professional counterparts, the paraprofessionals can share experiences of residing in the same locale. This, in turn, can lead to a greater sense of trust than between professional nurses and the mothers they visit (Hiatt et al., 1997, 2000; Olds et al., 2004). Similarly, past or current mothering experiences that the paraprofessional brings to the home visit may serve to alleviate the mothers' anticipation of unrealistic expectations and divergent beliefs often expected of professionals such as nurses (Mitchell & Green, 2002).

Although not all paraprofessional home visitors are volunteers, those who are volunteers may offer a service that has additional benefits to new mothers. In many ways, these benefits are similar to those found by programs using paid paraprofessionals. For example, the closeness or emotional bond between the volunteers and the mothers they visit is similar to that between paid paraprofessionals and the mothers they visit, in both cases augmented by their openly shared experiences. It is important to note the way in which the element of volunteerism contributes to the reciprocal nature of the volunteer–mother relationship. This reciprocity is largely absent from the relationship a mother has with a paid professional. If the mother feels that her visitor is making a personal choice to spend time with her and that the visitor herself has also experienced the maelstrom of postpartum emotions and challenges that she is experiencing, she is more likely to engage in an authentic relationship (Paris & Dubus, 2005; Taggart et al., 2000). The volunteer is likewise more capable of experiencing empathy and authenticity in part because of her own mothering experience.

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Examining an Intervention in Action: The Visiting Moms Program

The Visiting Moms Program is a home-based primary prevention program for mothers, infants, and families at risk of isolation, depression, or child abuse and neglect. The three theories of Stern (1995), Slade (2002), and the RCT group (Jordan et al., 1991) outlined previously serve as the backbone of the program's intervention, which is characterized by its participant-centered relationship-based services. The program is staffed primarily by home visiting volunteers, about 75 per year, and 6 paid master's-level clinical supervisors who function as regional coordinators. It operates from a community setting in a suburb of a major metropolitan area in the northeastern United States. Typically, the program services approximately 130 families per year. The participants are mostly new mothers primarily referred to the program within weeks of their infant's delivery by nurses, social workers, physicians, or themselves because of isolation, anxiety about parenting, lack of support, or limited resources. Approximately 50% of program participants are struggling with postpartum depression, and close to 30% have significant symptoms of depression, as measured by the Postpartum Depression Screening Scale (Beck & Gable, 2000), which is administered by the intake clinician. The clients come from more than 50 communities around the metropolitan area and represent a range of incomes, races, religions, and ethnicities. Home visiting services are available for up to 1 year at no cost to the client. United Way funds and other private donations financially support the program. Approximately 45% of families are seen for 9 to 12 months, 40% for less than 6 months, and 15% for shorter periods of time. Services are terminated typically when mothers need to return to work, the needs of the mothers have been met, or mothers are no longer interested in the services provided by the program. Approximately 20% of referrals do not lead to active cases.

In 2004, agency follow-up data determined that 98% of mothers reported satisfaction with services from their home visitor, 79% reported positive changes in their comfort level as a mother, and 89% reported decreased feelings of isolation. Findings from a qualitative evaluation of The Visiting Moms Program (Paris & Dubus, 2005) found that clients were able to identify the specific ways that their

home visitors were helpful to them by using techniques such as validation, affirmation, consistency, and emotional and instrumental aid. With these specific tools, the home visitors were able to enhance the mothers' self-confidence in caring for their infants, reduce painful feelings, and increase interpersonal connections.

The actual process of developing a volunteer home-based intervention in a community agency is complex and rarely discussed in detail. To fill this gap, we next describe some aspects of program implementation for readers who might be interested in initiating such programs or providing such services. In addition, we describe the agency's supportive matrix offered to the volunteers who mirror this approach with the new mothers they visit. Before describing these program elements, we present a case vignette to help the reader picture the client population, the volunteer's role, and the potential benefits to the new mother.

> Maria is a young mother who is new to the United States from Colombia and without available family support. Her father died when she was young, and her mother and siblings remain in Colombia. She is overwhelmed by the demands of her newborn, Alicia. Her husband, a non-Hispanic from the United States, works long hours. He tries to be supportive when at home but is unsure of what to do with the baby. The intake worker who is screening Maria is concerned about a possible postpartum depression, but Maria rejects the idea of seeking psychotherapy. Maria is matched with an older, experienced volunteer, Gloria, who listens attentively and normalizes many of Maria's feelings. Gloria empathizes with the exhaustion and isolation and offers to hold Alicia so Maria can eat lunch. Slowly, Maria admits that she resents living in the United States; she misses her family, resents not being able to share her baby with them, and is sad because she has no friends nearby. She also shares that her in-laws are very judgmental of her parenting style and constantly criticize her handling of Alicia. Her husband does not advocate on her behalf. Over the course of the visits, as the baby settles into a predictable schedule, Gloria suggests that the three of them take walks and encourages Maria to connect with other mothers in her neighborhood. Together, Gloria, Maria, and Alicia go to parks and attend a mother–baby support group. Gloria helps Maria reconcile her feelings of resentment toward other mothers who have families nearby. In time, Maria tells Gloria that the volunteer has helped to make her feel normal by not telling her what to do. No one, not even Maria's absent mother, could have fulfilled that role. Over time, Maria's depression and isolation abated.

Recruiting Volunteers for Home-Based Work

In the Visiting Moms Program, used as an example here, home visiting volunteers are recruited through community publications, electronic and community bulletin boards, and word of mouth. Publications indicate that the agency is looking for women who can devote approximately 2.5 hr/week for a minimum of 1 year (which includes home visits and biweekly supervision groups), have a car, are willing to drive to women's homes, are mothers themselves, and have a desire to help a new mother. When a prospective volunteer contacts the agency and indicates she wants to join the program, she is typically interviewed by the supervisor of services for her geographic region. The program prefers that this interview is conducted in the volunteer's residence as a way for her to experience a stranger entering her home. The supervisor assesses the woman's capacity to serve as a supportive nonjudgmental home visitor and as an experienced mentor mother. Is she easy to talk to? Does she make eye contact? Does she seem open to other people's ideas? Alternatively, does she have strong opinions that will get in the way of her ability to listen? Does she have the capacity to listen, or is she focused on doing the talking? The agency is looking for volunteers who can be self-reflective and demonstrate an interest in and connection to a new mother. The prospective volunteer must be reasonably self-confident without being pompous about her abilities and experiences. In addition to the supervisor's observation of the quality of the prospective volunteer's interpersonal skills during this interaction, the supervisor covers specific topics: the prospective volunteer's (a) interest in and motivation for volunteering; (b) own experiences when she was a new mother in terms of her feelings and behavior, need for support, and the extent to which support was available for her at that crucial time in her life; (c) strengths she will bring to the program, difficulties she might have in her new role, and what she hopes to gain from the experience; and (d) time and travel limitations that might influence her ability to participate in training and supervision and function as an active mentor mother. If accepted, the volunteer is expected to make a 1-year commitment to working with a new mother and to be part of a supervision group for the entire time she is involved with the program. The group supervisor will be evaluating her work, and feedback is available from other more experienced volunteers.

Current volunteers range in age from their early 30s to early 80s; the majority, however, are in their 40s and 50s. Most have some college education, and many have advanced degrees in fields such as law, medicine, speech therapy, and nursing. Each of them is looking for a meaningful volunteer experience. Some have previous knowledge of volunteering. Typically, they remember new motherhood as a challenging time where they would have liked a home visitor for themselves. Many feel competent as mothers, with their children being of school age or older, and they would like to share their wisdom.

The supervisory staff works with the volunteers in training and ongoing supervision to dispel their inclination to give advice and encourage them to focus on listening to the needs of their particular new mother. All volunteers share the desire to help and a willingness to be a part of a supervision group and connect with other volunteers.

Training and Supervision: Mirroring the Program's Philosophy

New volunteers participate in a training group that meets for five 2-hr sessions. Six to 10 women are trained together, with sessions starting three to four times per year. The primary emphasis in these sessions is on the program philosophy regarding the centrality of relationships for human growth and development, communication skills, boundaries between volunteers and program participants, and education about the postpartum period. Topics covered during the sessions include (a) the history and workings of the Visiting Moms Program, (b) cultural and societal attitudes toward mothering and ways this might affect the new moms who will be visited, (c) parent–child interactions (normative and nonnormative), (d) self-esteem in parenting (the types of mother–child interactions that generally increase or erode self-esteem), and (e) the role of the home visiting volunteer in terms of listening skills, nonjudgmental responses, collaborating with the new mom in problem solving, and prevention of child abuse and neglect (unpublished Visiting Moms training manual, 2005).[1] In terms of child maltreatment, the volunteer is required to call her supervisor immediately if she sees something of concern between the mother and infant or any other family member. If the supervisor shares the concern, she will visit the family in their home and work with the volunteer. If necessary, the supervisor will contact the appropriate child protective agency. Completion of this initial training is required of all volunteers before they are assigned to visit a mother and infant.

The program's relational philosophy—that human growth and development occur best in the context of supportive relationships—extends to the staff's training methods and ongoing work with the volunteers. Providing support and nurturance for the volunteers is fundamental to the training sessions. The staff treats volunteers with the utmost respect, sharing stories and listening attentively to each person's experiences, questions, and concerns. Along with ensuring that the volunteers learn the didactic material, the staff sees the quality of staff–volunteer interactions as a priority. In this way, the staff strives to model connected and reflective relationships (Slade, 2002; Walker, 2004), thus preparing the volunteers for the types of relationships they will build with their clients.

In contrast to other volunteer mentoring programs, Visiting Moms volunteers are expected to attend supervision groups every other week for 2 hours for as long as they are part of the program. If attendance becomes difficult, the volunteer is encouraged to resign her position until she is able to make a full commitment. Supervision groups offer volunteers the opportunity to update each other on their progress, raise questions or concerns, and problem solve as a group about difficulties in their home visiting relationships. The supervisor uses a strengths-based perspective (Black & Kemp, 2004) by focusing on the positive aspects of the volunteer's work with her client. Supervisors point out parts of the relationship that the volunteer does not see. For example, often a new volunteer will not understand the importance of simply being present and listening to the difficult days a new mother has experienced with a fussy baby. The volunteer may see the need to offer very specific advice. The supervisor listens to the case, points out how the mother seems to relax over a few weeks and gain confidence in her parenting abilities, and emphasizes to the volunteer that the mother may need to find her own way by experimenting with methods to approach the baby. By having an attentive, nonjudgmental listener, one who has gone through a similar experience, the mother will be able to develop her unique style and strategy with her baby. On other occasions, the supervisor may encourage a volunteer to examine her own feelings when interacting with her client. As in traditional clinical work, a variety of feelings on the part of the client or clinician may inhibit or unconsciously direct the work. Supervision groups take on these issues by gently encouraging the volunteers to look inward at themselves. The supervisor, together with the other volunteers, may guide one volunteer to set a boundary by limiting the visit to the standard 1- to 1.5-hour period, and guide another volunteer to be flexible enough to attend a doctor's visit with her client rather than restricting her role to visiting the new mother at home. The agency wants volunteers to stay apprised of the difficulties faced by their clients. Similarly, the agency wants to stay apprised of the difficulties faced by volunteers in their work with clients. Volunteers are encouraged to contact their supervisors at any time about such difficulties.

Referrals and Assignment of Home Visitors

When the program director receives a client referral, a regional supervisor is assigned to conduct an intake in the prospective client's home. The focus is on the acuity of the new mother's needs, her available resources, and her appropriateness for the program. Because the agency has services in addition to the Visiting Moms Program, the new mother may be referred to in-house services such as support groups, lactation consultants, or home-based parent–infant psychotherapy for women with severe postpartum emotional difficulties or could be referred to programs outside the agency.

[1] Readers can get more information about the manual by contacting Debbie Whitehill at dwhitehill@jfcsboston.org.

The supervisor works to match the potential participant with the best possible home visiting volunteer to meet her needs. Is the new mother in great distress and needing an experienced home visitor who can accept all of her needs? Is the new mother quiet, and would she benefit from a home visitor who would help to draw her out? Alternatively, is she expecting a great deal from the program, necessitating a home visitor who feels confident and easy about listening, providing guidance, and offering resources? The supervisor also knows her volunteers, (e.g., whether a particular volunteer would be skillful with a woman in great emotional distress who needs to share painful feelings of loss, loneliness, and self-doubt or whether another volunteer would be effective in activities such as holding a baby and accessing local resources but could not be effective in listening to difficult feelings that she could not change). Geographic proximity between the new mom and the volunteer and the overall available time of the volunteer are always considered as well.

Volunteer–New Mother Relationship

The intervention begins when the volunteer calls the new mother and arranges a time to meet, soon after the volunteer herself receives the assignment from her supervisor. On the first visit, the main goal is to help the new mother feel comfortable with sharing her thoughts and concerns. The volunteer spends the majority of her time listening and assessing the new mother's needs. She may determine that the mother desperately needs someone to hold her baby so she can take a shower or eat a sandwich. Alternatively, another new mother may want to share her feelings of isolation, helplessness, and exhaustion; others may worry about their parenting abilities, disclosing feelings of frustration and fear that they will not know how to respond to the baby's needs. The volunteer may offer guidance about an easier way to hold a baby or share a similar experience she had in her first year of mothering. These approaches are used in the interest of being seen as a role model for the new mother. The volunteer engages in self-disclosure carefully, ensuring that it occurs in the interest of the client and not herself. This specific type of sharing is especially appreciated by many of the new mothers, because they feel more connected to the volunteer when they hear her experiences of imperfection and feel less alone in their fears and self-doubts. They are comforted knowing that a more experienced mother has also had the same worries (see Paris & Dubus, 2005, for detailed information on evaluation results).

After a few weeks, the new mother begins to look forward to regular meetings with her home visiting volunteer. The relationship deepens, and often the program participant begins to share more of her fears and self-doubts about mothering. The volunteer offers reassurance and universalizes the experience of the new mother. She strives not to judge the new mother's feelings or behaviors, but if she is concerned about these types of thoughts, the volunteer can share them in her supervision group. New mothers discuss a broad spectrum of personal experiences, including incidents of marital discord, disappointment in extended and immediate family for their absence or lack of availability, disappointment in friendships, struggles about when to return to the workforce or what type of job to seek, and ambivalence about childhood experiences and their own parents' behavior toward them. The volunteer continues to listen and observe. She may offer to help with the baby, take a walk so the three can get out of the house, or accompany the new mother to a particularly stressful appointment. She also watches the baby's development and raises concerns in her supervision group. This might lead the volunteer to suggest that her new mother accept a referral to an early intervention program or to a new mothers support group. As the volunteer notices the baby's behavior and development, she brings this to the mother's attention. In the service of helping the mother develop her own reflective function ability, enabling her to imagine, understand, and respond appropriately to her infant's mental states (Slade, 2002), the volunteer might ask the new mom if she has noticed that the baby is now smiling when the mother speaks or, on another occasion, that the baby looks like he or she is ready to crawl. Thus, the intervention provides the new mother with another adult engaged in and intensely interested in the process of witnessing the growth and development of the baby. New mothers report that this mutuality is especially important to them, and

> This constellation of issues, thoughts, feelings, and behaviors inevitably requires that the mother attend to specific challenges and concerns such as reflecting on her relationship with her own mother, developing her self-concept as a mother, and developing a relationship with her infant.

understandably so. Implicit in this interaction is the notion that the new mom is doing well as a mother if her baby is growing and developing. The volunteer is also feeling competent in her role as she watches the new mother feel increasingly self-confident and better able to parent her child in a relaxed and flexible way.

The final period of the intervention focuses on assisting the new mother to connect to supports other than the Visiting Moms Program. The new mother is encouraged to participate in community activities for mothers and babies and to reach out to friends and family when available. The volunteer will often point out how much the new mother's skills have grown and how competent she seems in caring for her baby. As the relationship moves toward termination, discussions include time for reflection on the past year and anticipation of the challenges and pleasures in the coming months. For example, what will it feel like for the new mother when the weekly visits have ended? How will the new mother find support and comfort when she encounters a particular challenge in parenting? Terminating the relationship can be difficult for both the new mother and volunteer. In the supervision groups, supervisors often spend time discussing the importance of being clear about ending the home visiting aspect of the relationship, yet a small percentage of volunteers remain in casual contact with the new mothers they visited by exchanging cards or speaking on the phone periodically.

A second vignette further illustrates the volunteer's relationship with the new mother.

> Tracey was referred by the social worker at the Newborn Intensive Care Unit of the local teaching hospital because of Tracey's anxiety about bringing her baby home. Henry was born prematurely at 30 weeks gestation. Although he was developing well, he had gastroesophageal reflux, so he needed to remain in an upright position most of the time. Tracey was instructed not to bring Henry out in public for at least 1 to 2 months. Her anxiety about Henry's health was so great that she held him in her arms day and night. She explained to Monica, the volunteer, that she was accustomed to having nurses and other parents around in the hospital but was now feeling very isolated in her tiny one-bedroom apartment. Tracey's husband, who had returned to work and arose early in the morning, was not able to get up at night for feedings. Monica suggested that her first visits provide respite; she would hold Henry so Tracey could shower, fold laundry, clean up around the house, cook dinner, or just relax with a cup of tea. Tracey and Monica could talk, but Tracey would get a break from holding the baby. For many months of the relationship, Tracey had a strong need to relive and reprocess her pregnancy, birth, and postpartum experiences because none of those experiences had gone as anticipated. During those meetings, she cried, got angry, and expressed feelings of guilt, feelings of jealousy toward other mothers, and her fears for her baby. Monica listened empathically and worked to normalize Tracey's feelings. As Henry grew bigger and flourished, despite a few medical difficulties, he was allowed to go outside. With this new freedom, Tracey felt better about herself as a parent but realized she was bitter toward family and friends for their failure to be available to her. Monica helped her to identify ways she could share her feelings with key people in her life. Many of these people have become important supports to Tracey and Henry now, after she was able to disclose to them her true feelings of isolation and anger. Henry is thriving, and Tracey, in turn, is feeling more confident in her caretaking abilities. Both Monica and Tracey are experiencing sadness in terminating their yearlong relationship.

Implications for Practice and Programming

Programs for at-risk new mothers can encourage authentic family relationships and healthy growth of young children by serving as part of a supportive matrix for the mother, assisting her in dealing with fears and worries about the baby and her mothering abilities and ultimately aiding her mastery of developmental tasks associated with new motherhood. Further, such programs can prevent child abuse and neglect in these acutely distressed families grappling with the birth of a new baby. We now discuss specific implications for practice.

Value of a Theoretical Perspective in Programming

The Visiting Moms Program, an exemplar of volunteer home visiting programs, is founded on the theoretical perspectives of client-centered practice, a strengths perspective, and relational theories (Jordan et al., 1991; Slade, 2002; Stern, 1995). In its specific relational perspective, the program is unusual among human service agencies. Many programs do not have an articulated theoretical approach (although they often subscribe to guiding principles that may be value based or utilitarian in nature) or are based on an eclectic approach involving the individual theoretical perspectives of many staff members. Having such a consistent perspective for the program has provided coherence to the screening, training, and supervision of volunteers. It has been especially helpful in guiding volunteers through the initial phases of their relationship with the new mother when they experience intense pressure from inside themselves to do something tangible to make the situation better. Relational–cultural theory, in particular, validates their being with the new mother through these critical experiences and bearing witness to her pain, struggles, and accomplishments in mothering. Relational–cultural theory,

in its emphasis on reciprocity in the relationship and the need for each woman to follow her own developmental pace, validates the volunteer's use of moderate self-disclosure and helps her in the termination phase when she is reluctant to leave the new mother on her own or inclined to fault herself for not helping the new mother accomplish more. Having seen the value of the consistent relationship that has emanated from this philosophy and its positive effect on staff, volunteers, and new mothers, we encourage other programs to identify and articulate their theoretical frameworks and ways it can be implemented. Although more programs are beginning to articulate their philosophy to respond to funders who want more evidence of effectiveness, we see this as a high priority over the short term.

Unique Contribution of Volunteer Home Visitors

The volunteers described here offer a type of service that is unique and differently effective than programs using paid professionals. The mutuality and authenticity that are hallmarks of these home visiting relationships serve to empower these isolated new mothers and enable them to move forward in their mothering careers. Our perspective is that volunteers, rather than being more effective than professionals, fill a gap in services, especially for mothers who refuse professional services or who live in communities not covered by professional home visiting services.

Some cost savings are inherent in using volunteers instead of professionals; however, programs would be naive to calculate costs in an equation of volunteers versus professional home visitors. Volunteers need a parallel system of support to the one they provide to new mothers. Thus, the cost of careful recruitment, screening, training, and supervision by professional staff must be factored into any program design based on providing such volunteer services.

Program planners can extrapolate from the model presented here by using volunteers to augment services in other types of community organizations such as youth mentoring (Rhodes & Spencer, 2005), school-based programs, and services to homebound older adults. Key to success would be paying specific attention to the relationship-based services and processes to increase recruitment and retention.

Volunteers and New Mothers: Working Across Social and Cultural Differences

In the program highlighted here, the volunteers tended to be more financially and socially stable than the new mothers they were visiting. This is understandable because the type of woman seeking a volunteer experience rather than a job is generally one who is financially secure. Supervision seems to be effective in helping volunteers deal with their feelings about the disparity between their personal resources and those of their new mothers and responding to new mothers who occasionally raise this issue. Similarly, training and supervision address cultural competency, because there are more women of color among the new mothers than among the volunteers. However, program planners might consider whether recruiting volunteers from a broader socioeconomic and racial–ethnic spectrum would be helpful to the new mothers (if it were possible). In the program described here, the primary selection criteria were very good interpersonal skills and availability.

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