A Home-Based Intervention for Immigrant and Refugee Trauma Survivors:

Paraprofessionals Working With High-Risk Mothers and Infants

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Marta, 23 years old, was referred to the Visiting Moms Program by her obstetrician when she was 3 months pregnant with her first child. Speaking only Spanish, she had come alone from Mexico fleeing poverty, family violence, and limited opportunities. Marta was bewildered when diagnosed with a sexually transmitted disease during a routine prenatal exam. Her boyfriend told her that she must have contracted the disease at the clinic. Marta was isolated, depressed, and without access to information. Susanna, the home visitor assigned to Marta, was also a Mexican immigrant. She explained the nature of sexually transmitted diseases to Marta and stressed the importance of completing the full course of antibiotics. Consequently, Marta considered leaving her partner but was too fearful to do so in light of her pregnancy and isolation. Susanna was there to hear out her struggle.

The pregnancy was difficult; Marta was frightened and depressed. Susanna made weekly home visits, encouraging Marta to share her depressed feelings with her doctor. That process was foreign to Marta, but with Susanna's encouragement, she talked with her doctor and was prescribed antidepressants. Susanna's support made Marta feel less alone and prompted more sharing of her questions and concerns for her baby. Susanna eventually introduced Marta to the public library where she could read about the stages of the developing fetus growing inside of her and learn that taking care of herself was central to caring for her baby.

Reading about nutrition was one type of challenge, but having enough money for food was another. Marta had held a job, but had to quit when she became pregnant. Susanna introduced her to the local Salvation Army where she obtained food, and suggested that Marta might like to volunteer there while she was pregnant. For 4 months, Marta worked with older adults until her delivery. Her isolation was lessened, her self-esteem grew, and she received a bag of groceries each week.

abstract

This article describes how the Visiting Moms Program in Chelsea, Massachusetts, has taken the paraprofessional model one step further to respond to the needs of refugee and immigrant new mothers, by employing paraprofessional home visitors who are also immigrants or refugees themselves from countries in Central America, South America, and Africa (e.g., Brazil, El Salvador, Sudan, Somalia, and Morocco). This home-visiting intervention, located at the Massachusetts General Hospital Chelsea HealthCare Center, demonstrates how paraprofessionals who are also mothers and closely connected to their communities can work effectively with families with multiple risk factors, including trauma. With extensive training and close supervision by a senior clinician and program administrator, the resources of a well-coordinated community health team and outstanding health center, these multilingual/bicultural home visitors provide emotional support, client advocacy within the service system, and education on child development for low-income, high-risk immigrant/refugee families.

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Marta had a healthy baby girl, Carolina, but postpartum depression and anxiety interfered with their bonding. She shared with Susanna that Carolina could be anyone's baby and that she did not feel like a mother. Susanna reassured her and supported her mothering of Carolina. She answered Marta's questions. Why does the baby put everything in her mouth? Why does the baby look so serious all the time? Marta's initial feelings of helplessness were met with Susanna's patience and compassion. Marta slowly began to feel more at ease in her mothering role, feeling confident enough to venture out to meet other new mothers. She attended a support group for new mothers, with Susanna as a facilitator. Carolina is now growing up with a more vibrant and nurturing mother and in a safer home environment.

Home Visiting for High-Risk Immigrants and Refugees

Like Marta, many immigrants and refugees relocate to the United States to improve their lives and those of their children. Experiences in their home countries often involve poverty and oppression, and sometimes violence. In spite of coming to the United States to improve their economic situation, most newcomers live in impoverished conditions and have minimal social support. They have lost much of what constitutes the fabric of their daily lives, including extended family and community, as well as their cultural framework for parenting. In addition, many have suffered trauma from political conflicts and violence experienced in their home countries, during travel to the United States, and in the process of adaptation to their new environments (Perez Foster, 2001). These types of life experiences are risk factors for child abuse and/or neglect (Birman et al., 2005) because of the psychological, social, and economic difficulties they create, leaving parents unable to adequately care for their children. As a service to many high-risk families, paraprofessional home visitors have delivered services to prevent child maltreatment and improve the life course of the mother (Jacobs, Easterbrooks, Brady, & Mistry, 2005; Hiatt, Sampson, & Baird, 1997). The community connections and life experiences of these home visitors, who are usually parents themselves, enable them to empathize with the mother, influence her motivation to use resources, and help her feel effective in her parenting role (Taggart, Short, & Barclay, 2000). However, few service models specifically address the needs of immigrant and refugee mothers and children.

Trauma and Immigration

Current immigrants arriving in the United States, as well as in other affluent countries, are searching for economic opportunities that have characterized immigration for hundreds of years. They are seeking safety and freedom by fleeing from oppressive and war-torn regions of the world. Those that arrive in our communities are often women, men, and families with very young children, escaping oppressive poverty, disintegrating families, detention, torture, malnutrition, and wartime violence. Most have lost important family and community connections. Some have experienced torture or watched violence being perpetrated against close family members. Many were driven from their homes and relocated temporarily in the relative safety of refugee camps until permanent homes were found (Perez Foster, 2001).

The flight from poverty or war ravaged countries in Central America, Africa, Europe, and Asia can be traumatic. Fleeing by foot through desserts and forging swollen rivers under the guidance of an intimidating illegal travel broker are common experiences for Mexican and Central American immigrants. Africans who are aided by relief organizations, due to their refugee status, have typically spent years in refugee camps after the loss of home and families. Regime changes in the Middle East and Eastern Europe frequently precipitate quick departures by individuals or parts of family units for fear of repression or torture by new governments. Fear precipitates flight to any available country, and often families are split up and spread all over the globe. Some Central American, Mexican, and Filipino women, anxious to escape poverty and disintegrating marriages, leave children behind with grandparents or extended family and become "transnational" mothers (Hondagneu-Sotelo & Avila, 1997). All such immigrants and refugees, relying on strangers for transport and safety, arrive in the United States with limited resources.

Immigrant and refugee mothers may be limited in their ability to effectively nurture an infant or young child due to their own depression, anxiety, or posttraumatic stress symptoms. They also may be confused about parenting expectations in their new country.

Many formerly lived in small villages; now they find themselves in urban environments, unable to speak the language or negotiate cultural norms. The resettlement process is difficult at best. The cost of food, clothing, and shelter is more than they had imagined. Living in a cold climate necessitates sweaters, coats, and boots, often unfamiliar articles of clothing to them. Finding employment is difficult because of the language barrier. The urban communities where they live are often poor and rundown, with street violence that keeps women and children locked inside small apartments for hours or days at a time. When contact with "helpers" such as health care providers does occur, the immigrant parents may be instructed to care for their children in ways foreign to them; they may be discouraged from using culturally familiar practices like herbal remedies or charms to ward off illnesses or unfriendly spirits.

Impact of Trauma on Mental Health and Family Life

Many immigrants develop strength and resiliency in the face of these hardships. Immigrants and refugees typically work hard and encourage their children to adapt and thrive in their new country. However, traumatic experiences can negatively affect physical and psychological well-being, with noted increases in substance use and family violence. Many immigrants and refugees suffer from anxiety, depression, and posttraumatic stress symptoms (Blackwell, 2005; Perez Foster, 2001). More specifically, some women with young children who are not participating in the workforce can be isolated and struggle with limited human contact and conversation. This can lead to social isolation, precipitating mental health difficulties. The first year in the United States is typically very lonely.

Immigrant and refugee mothers may be limited in their ability to effectively nurture an infant or young child due to their own depression, anxiety, or posttraumatic stress symptoms. In addition, they may be confused about parenting expectations in their new country. For example, upon discharge from the hospital after delivery, mothers may be handed infant formula with few instructions—the mother's interpretation may be that breastfeeding is unacceptable or is an inferior nutritional alternative. Health care providers' expectations for frequent mother–infant physical nurturance and bonding may be difficult for the mothers to live up to given life stressors or cultural norms for parenting in their new country. In addition, the mother's other young children may have experienced trauma themselves from witnessing violence in their home countries or in travels to the United States. Parents may not understand the child's current or potential difficulties in light of this history.

Symptoms caused by traumatic events are categorized as (a) reexperiencing the trauma (e.g., flashbacks), (b) avoiding the trauma (e.g., symptoms of depression, feeling detached from others), and (c) increasing arousal (e.g., difficulty falling asleep, irritability, difficulty concentrating). The work of Lieberman (2004) and others (Moro, 2003) shows that mothers struggling with their own unresolved trauma have difficulty providing an optimal base of security for their children. The mother may not be able to soothe the child's fears when she is immersed in her own sadness and pain. The child may witness the mother as unable to function in the new environment. Given these scenarios, and adding the stressors of poverty and unemployment, attachment difficulties are likely.

Benefits of a Home-Visiting Intervention for Immigrants and Refugees

Research suggests that the highest risk families, such as those living in poverty or struggling as newcomers to the United States, benefit the most from home visitation (Gomby, Culross, & Behrman, 1999). In many home-visiting programs, the nature of the relationship between the mother (most often the main program participant) and the home visitor is the very foundation of the program's process, progress, and success (Heinicke & Ponce, 1999; Paris & Dubus, 2005). Through the established relationship between the two women, the home visitor provides emotional and practical support, education, role modeling, and

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companionship for the new mother. The home visitor may also help her to initiate other activities when needed, such as making alternative housing arrangements, scheduling pediatric appointments, or visiting with attorneys regarding immigration. The multilingual/bicultural home visitor can aid the new mother in learning the practices of the host country (e.g., by explaining the pediatrician's expectations and by clarifying confusing laws and unfamiliar documents). In addition, she helps the new mother consider both ethnically traditional and mainstream health services.

The MGH Chelsea HealthCare Center Visiting Moms Program

Child abuse prevention programs face many challenges in developing home-visiting interventions for non–English-speaking families who are immigrants or refugees, are struggling with the impact of traumatic histories, and are often mistrustful of outsiders. In spite of the language differences and the slow process of gaining client and community trust, the Massachusetts General Hospital (MGH) Chelsea HealthCare Center, with support from the Jesse Ball DuPont Fund and the Community Benefits Program, implemented this innovative culturally sensitive home-visiting program in 2002. The city of Chelsea is diverse and routinely ranked as one of the poorest in Massachusetts (43% of families have incomes less than 200% of the poverty rate, and more than 39% of children under age 18 are living in families with incomes less than 100% of the poverty rate). Of the documented residents, half are Latino, many of whom speak only Spanish. The remaining residents are 38% White, 7% African American, and 5% Asian, with emerging populations from Bosnia, Somalia, Brazil, Sudan, Kenya, Vietnam, and Central and South American countries. Of importance, Chelsea has the second highest rate of child abuse and neglect in the state, although it is one of the smallest cities.

The home-visiting paraprofessional, multilingual/bicultural staff of the Visiting Moms Program are immigrants as well. They intervene using a relationship-based model (Lieberman, 2004) that includes emotional support; education on child development for the mother and other caregivers; advocacy for the family within the medical, educational, mental health, and social services systems; and referral to community resources such as food pantries and parent support groups. In addition, the paraprofessionals' work with the new mothers is continually filtered through an observational lens of trauma. That is, the paraprofessionals are trained to understand the nature of trauma, how to identify its effects, and how to respond appropriately. Given that many of these home visitors have also personally experienced trauma as migrants to the United States, they readily understand the importance of this issue and the benefits of providing support and helping with the healing process. Home visits can be provided for up to 3 years. A sizable number of mothers and young children with the greatest needs remain in the program for the entire time, although the average duration of services is about 11 months.

Who Can Participate in Visiting Moms?

Obstetricians, midwifes, pediatricians, or psychotherapists from the MGH Chelsea HealthCare Center refer pregnant women and new mothers to the Visiting Moms Program. Although the health center had hoped to provide home-visiting services for all new mothers, limited resources have required program leaders to prioritize new mothers at the highest risk and in the greatest need of home-visiting services. To screen applicants, and to determine which mothers were at high risk, program staff assess factors related to the mother (e.g., severe isolation, extreme cognitive limitations especially of first-time mothers without family support, severe depression, risk of abusing the child, attachment difficulties between mother and child), the child (e.g., overwhelming health needs, marked developmental delays), and the family environment (e.g., the risk of physical harm to the child, domestic violence).

What Are the Characteristics of Program Participants?

Demographics. Of the 105 participants since the program's inception, approximately half are first-time mothers and half are pregnant when referred. All participants are delivering babies in the United States for the first time. Their average age is 28 years, with three quarters of the mothers under age 30. Most participants (three quarters) are partnered, and 70% of fathers stay involved with the women and children. The vast majority of mothers have household incomes under $20,000, often receiving some government assistance. Countries of origin span the globe, with more than 60% of the women coming from Central America, Mexico, and the Caribbean; 25% from Africa; 5% from the Middle East; and the remaining women from countries such as Afghanistan and China. Languages spoken include Spanish, Somali, Swahili, Arabic, Portuguese, Dari, Farsi, Cantonese, and English. More than 50% of the mothers have had some elementary or middle school edu-

cation in their home countries, and 26% attended and/or graduated from high school. A few women attended college or trade school; at the other end of the spectrum, 10% have no formal education. Most of the women from Somalia are illiterate in their native language, as are some women from Central America.

Parent–child interactions. A health care provider has deemed all of the children at risk of child abuse or neglect due to circumstances beyond their immigration status. Harsh interactions between mothers and children or gross misunderstanding of child care expectations from a Western perspective are flagged as signs of risk. The mothers struggle to maintain their traditional child-rearing practices but often lack the cultural framework (e.g., extended family close by, access to religious services and healers) to continue their parenting customs. For example, the desire to protect a child by placing an herbal remedy around his or her neck is seen as dangerous by a health care provider and as a possible source of choking. The immigrant/refugee mother does not understand why she is being discouraged from caring for her child in the same way her mother and grandmother cared for her. Everything familiar that formerly surrounded these women has been lost: homeland, language, culture, family, and friends. Despite having been raped in a refugee camp in Kenya, one gentle African mother spoke of her loss in this way, "Here I have food for my belly, there I had food for my heart."

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Additional family stressors. Most participants struggle with the language barrier, family unemployment, inability to access financial benefits, and severe lack of funds. Some mothers have inadequate housing, often living in one-bedroom apartments with their child/children, partner, and two to three other housemates. Few have close family in geographic proximity. For many, the impact of migration has led to family problems such as excessive arguing or emotional or physical abuse from their spouse or partner.

Halima exemplifies the women the program was designed to serve.

Halima was one of the first mothers referred to Kadija, a Somali refugee who is now a home visitor in the Visiting Moms Program. Arriving in the United States 3 years earlier from Tanzania, Halima was 20 years old and knew no one in this country. Her native language was Swahili, but she learned English while in the United States. She was undocumented at the time and seeking asylum, so she was not permitted to work. Halima got involved with a man from her country, became pregnant, and began receiving care at the OB Clinic at MGH Chelsea HealthCare Center. She impressed those who met her with her indomitable spirit, but staff also saw her desperation. She feared being deported, she had no source of income other than earnings from her boyfriend's intermittent odd jobs, she was without family or a community of friends, and this was her first pregnancy. Her obstetrician referred her to the Visiting Moms Program.

Baby Leza was delivered by a difficult cesarean section. Although Leza was healthy, Halima did not heal quickly. She was anemic and isolated. Her legal, financial, and medical needs seemed overwhelming. Halima found that developing an attachment to Leza was difficult through the thicket of anxiety and depression. Kadija visited Halima every week. Conversations focused on Africa, home, and family left behind. Halima told stories of her immigration and of reconciling her fantasy of life in America with the reality of living in a foreign land without familiar guideposts. Kadija had an attentive ear and understood Halima's experiences. The conversations between the two women began to infuse new life into the two crowded rooms Halima, Leza, and the baby's father shared with another housemate.

Halima's depression began to grow less weighty. She started noticing how Kadija interacted with the baby. The play was exuberant with lots of holding, touching, and laughter. Leza responded with wide smiles and bright searching eyes. Halima began to join in, tentatively at first. Her questions reflected her worry that she did not know enough to be a mother. "Would it be safe to put a necklace around the baby's neck?" "Will it hurt her to braid her hair?" Africa may have been thousands of miles away, but with Kadija there some of Tanzania was coming to life now in the small Chelsea apartment.

Kadija linked Halima with legal services to help with her quest for legal asylum. She referred her to the MGH Project Rise, providing training and work for women hoping to become self-supporting. Halima was put on the wait list. Meanwhile, she continued to worry about providing for her child. Kadija brought clothes for both Leza and Halima from donations received at the health center. She helped her to apply for welfare assistance, food stamps, and the Women, Infants, and Children Food Program; Halima received a breast pump, toys, and information about feeding, nutrition, and infant development. With Kadija there, Halima's confidence grew, and bit by bit, she developed a deep affection for her baby. Leza was thriving, becoming a robust, smiley, girgling, wiggly little girl.

Unfortunately all was not well in Halima's partner relationship. She tearfully confided to Kadija that the baby's father had been unfaithful and physically abusive to her. She was frightened and unsure of what to do. There was some relief in allowing Kadija to know the worst. However, she loved the baby's father and wanted to make the relationship work. One night, after a particularly bad fight in which her

partner became verbally assaultive and hit her with a phone, she called the police and he fled. She also called Kadija who offered an option for safety in the health center's program for battered women. Within hours, Halima and Leza were in the safety of a shelter. But, the question of where they would live loomed large. Halima's welfare income would not be enough for rent.

While Halima was in the shelter, Kadija was the one to learn that Project Rise had accepted Halima into its training program. Her enthusiasm, intelligence, and resilience had impressed them. Halima could start her training in 2 weeks, but Kadija had no way of notifying her because the shelter's location was fiercely guarded from everyone. Time was short. Kadija and her supervisor contacted staff members from the health center on a team that worked closely with the local police on domestic violence cases; police were able to lead them to Halima.

When hearing that she had been accepted for training, Halima was elated. Kadija helped her locate appropriate child care for Leza. In a final stroke of good timing, immigration services granted her refugee status. She obtained a green card. With growing autonomy and hope for improved financial security, Halima has more options. She does not have to raise her daughter in a home fraught with violence.

What Are the Characteristics of the Immigrant/Refugee Home Visitors?

Home visitors in the Visiting Moms Program are paraprofessionals chosen for their compassion, patience, resourcefulness, and interest in working with mothers and babies. As bicultural and multilingual staff, they often are the only ones capable of fostering trust deep enough for the health center to fully meet the needs of the immigrant or refugee mothers. Each home visitor knows from her own experience the trials of being a mother while being a newcomer to the United States. Similar to the clients they serve, some home visitors are from countries with current or recent histories of bloody civil war, even genocide. Each has left behind her family of origin, and several have no relatives in this country. Two former home visitors are themselves graduates of a home-based intervention.

Among the numerous attributes important for home visitors to possess, compassion is what is most needed to guide a home visitor who works with high-risk mothers and infants. She must also possess the ability to tolerate knowing and examining strong feelings and conflicts within herself that will inevitably arise in the work. Her ability to temper self-judgment and engage in healthy forgiveness is also essential, as she will confront broken situations that she will be unable to mend. Feelings are often very intense when working with traumatized individuals. A home visitor's ability to tolerate seeing the worst of that which troubles the mothers in the program, and to stand by without harsh judgment, is rooted in her skill to do the same for herself. Training and supervision (described next) help foster this knowledge and model a nonjudgmental position.

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Visiting Moms Intervention

Initiating and Developing the Relationship

The Visiting Moms Program at MGH Chelsea HealthCare Center is a strength-based intervention that supports its clients' best parenting practices. However, the newly referred mothers are often wary of the home visitors because they fear immigration authorities and are distrustful of the Western medicine represented by the home visitors. Yet, the woman who calls them and then appears at their door is another immigrant mother, one who speaks their language and shares their culture. The home visitor's first focus is to develop a relationship with the mother, listen to her needs, and respond to her questions. She serves as a "cultural broker," explaining the various instructions that the mother has received as well as demystifying the workings of numerous agencies with which the mother has had contact. Simultaneously, the home visitor is conducting an assessment. Does the family have adequate food, clothing, and shelter? Is the child safe? Does the mother have any supports? Is the father of the baby involved? Is there a notable mental health problem? The home visitor continues by considering the nature of the relationship between the mother and infant. Who does the baby represent to the mother? What hopes, fears, joys, or burdens does the child bring? Home visitors weave evaluation questions into initial home visits and administer standardized inventories (the Beck Depression Inventory II (Beck, Steer, & Brown, 1996) and Parenting Stress Index (Abidin, 1995) at the beginning of the intervention and at 6–8-month intervals to assess change.

The home visitor begins by listening and often learns that families need basic supplies. The health center and community collaborators are able to provide resources such as food, baby clothes, cribs, strollers, car seats, and more. For example, home visitors can make referrals to an early intervention program, a preschool for an older sibling, or an English as a Second Language (ESL) class. In the beginning, it is the concrete resources and referrals that the mothers may value the most.

Developing a Working Alliance

Trust builds between the mother and the home visitor as each one gets to know the other with each visit. The home visitor increasingly responds to questions about the infant's care and development. She models how to play with the baby, stimulate him, soothe him, or breastfeed. With the guidance of the home visitor, the mother can maintain traditional child-rearing practices when they do not endanger the baby. The home visitor–mother relationship can become more intimate as mothers share troubling truths about their lives. Trust begins to overcome shame. One mother tells about her emotionally or physically abusive boyfriend, another about the drug addiction of a housemate, and one about the reliance on money from prostitution. The safety of the children is continuously reassessed in view of new information.

The home visitor functions in many roles with her client. She is a nurturer, mentor, teacher, guide, and advocate. Given that teaching and advice giving are central to the relationship, the home visitor may share a personal experience from her life in order to demonstrate a particular point. Such information is only shared with the goal of helping the client and never includes current unresolved concerns that may evoke worry or the need to take care of the home visitor. As a model, the home visitor holds, hugs, and plays with the children. Hands-on guidance with grocery shopping and cooking, as well as sharing recipes, may be part of the intervention. All activities associated with these roles foster the mother's health, competence, and autonomy.

Expanding the Relationship to Community Supports

The home visitors look for ways to connect isolated women to their communities. This may come in the form of English classes, help in obtaining a library card, or guidance in seeking employment. In an ESL class, an unlikely friendship developed between a Latina mother and a Somali Bantu woman. A multicultural Mother's Day lunch and a trip to a science museum brought many of the clients together.

In addition to community connections, the home visitors rely on collaborations with staff of the health center and other agencies, interactions vital to the well-being of the staff and the program itself. They consult with the pediatricians about the growth and development of a baby and make referrals to providers such as psychotherapists and psychopharmacologists for medication within the mental health department, domestic violence specialists, legal services, and child protective agencies. As work with the mothers and infants progresses, it can be extremely intense as traumatic pasts are discussed or current family violence is addressed. The home visitors maintain their role as advocates for their client by staying in contact with these additional care providers and often coordinating services or serving as interpreters. She may be the most trusted of the caretakers and her role is often central, but she does not act in isolation.

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Nadia's work with Zara typifies the way home visitors rely on a senior clinical supervisor and collaborators in the health center, particularly with regard to a mother's history of trauma.

> *Zara, an educated English-speaking woman, was relatively well-off in Iraq. Her family lost everything when they left their homeland and came to the United States via Germany. They now fight feelings of shame at their lowered economic status. Her mother and sister live with her in Chelsea, but her husband remained in Germany. Zara, referred to the program after delivering her first child, a healthy boy, appeared to suffer from postpartum depression. As her home visitor Nadia got to know her better, she could see symptoms of paranoia with poor judgment and sometimes bizarre behavior. Her erratic judgment put her baby at risk, as she was seen without a coat in the middle of winter sitting on a curb with her son. She was referred to a psychiatrist at the health center, evaluated, diagnosed with a delusional disorder, and treated with medication, which helped. However, she was not always medication compliant. She did not accept the diagnosis of mental illness. Her mother and sister were shamed by Zara's psychosis and reacted by distancing themselves. She was referred to a licensed social worker for therapy and kept the appointments regularly at first, but over time more erratically.*
>
> *Zara was most open when the Nadia, another Muslim woman, came to her apartment, and she seemed curiously*

relieved that Nadia was Moroccan. She feared another Iraqi would tell her secrets to the rest of the small Iraqi community. It was clear that she loved her baby and that she missed his father. Talk of their separation led to memories of long ago and other more traumatic separations. She had memories from childhood of blood in the streets of her native city. Zara remembered soldiers dragging her father and uncle out of the house and taking them away.

Nadia discussed Zara in supervision. The supervisor began to realize that Zara's behavior was possibly a sign of posttraumatic stress disorder (PTSD) rather than an intractable psychosis. This did not change the medication, but the prognosis became much more hopeful and less weighted with shame. This new understanding of Zara's episodes of bizarre, paranoid behavior created an opening to help the family better support her. With Nadia and another Muslim staff member as coordinators, Zara agreed to meet with her mother, sister, and the psychiatrist to talk about the PTSD, the need for the mother and sister to keep a closer eye on the baby, and the need for Zara to take her medications regularly.

Zara's husband is now with her, and she has given birth to a second child. She still meets with the psychiatrist but went without antipsychotic medications during her pregnancy. Life is calmer; the concerns are less acute. Although the psychiatrist recently became worried about Zara's harsh reactions to her toddler's jealousy of the newborn, with Nadia's calm nonjudgmental manner, Zara was receptive to being educated about the normal jealousy of siblings.

Training and Supervision

Initial training of home visitors was conducted by staff from Greater Boston Jewish Family and Children's Service, where the Visiting Moms strength-based, home-visiting approach was developed more than 17 years ago (Paris, Tierney, Kaufman, & Whitehill, in press). Staff met with the trainers for 1½ hours each week for 6 weeks. Topics included cultural and individual variations in parenting, the home visitors' experiences in their home countries and as immigrants/refugees in the United States, building a trusting connection with a client, active listening) and nurturing self-esteem. The home visitors were encouraged to remember their own parenting experiences as both a child and a parent. Parent–child relationships were discussed with a particular focus on how personal parenting experiences influence one's own parenting style. Given that a program goal is to enhance the mother's independence from the home visitor and develop greater connection to community supports, the home visitors were trained in methods of accessing and sharing resources and the various steps in problem solving. Most important, screening for abuse and neglect was emphasized, including a discussion of identifying risk factors and reporting the problem in supervision and, when necessary, to child protective services. Ongoing training includes seminars given by health center staff on topics such as physical and mental health (including emotional reactions to past trauma), child development, family violence, and parenting. In addition to weekly individual supervision, the home visitors meet monthly as a group with their supervisor. The goals of this meeting include team building, problem solving, resource sharing, teaching, and support.

A goal in supervision is to help the home visitor become conscious of her own history and how it affects her views and reactions.

Supervision with an experienced clinical social worker takes place each week for 1 hour, although the program supervisor and administrator are available throughout the week to help with crisis intervention. Supervision strives to model similar experiences that home visitors will provide their clients: mentoring, teaching, and guidance. It can be a time of sharing the joys and burdens of the job; it is meant to be a safe place for expression and understanding of the strong feelings evoked by their work.

Some or all of a home visitor's clients may be reviewed briefly by discussing goals, plans of action, and progress. When crises do arise, troubleshooting on behalf of one family may fill the hour. The client's abilities and vulnerabilities are assessed with a view toward capitalizing on her strengths. The focus may be on the baby's health and development and the evolving attachment to the mother. Obstacles to the mother's emotional or physical well-being are common problems that are examined with specific awareness of how they may interfere with her ability to nurture her child. With clients who are immigrants and refugees, a home visitor's supervision often includes discussions about how the origin of behaviors and symptoms can be drawn from a long-ago trauma. A home visitor and her supervisor discuss various referrals, such as psychotherapy or psychopharmacology, as well as a battered women's program, assistance in applying for subsidized housing, or legal services. Careful consideration is given to the client's potential reaction and to sensitive ways to broach each issue.

A goal in supervision is to help the home visitor become conscious of her own history and how it affects her views and reactions. Each visitor was a child being parented, a woman who experienced pregnancy and childbirth, and now a mother raising children of her own. Each is also an immigrant or refugee with a history that enables her to empathize with the client's experiences, which can make her vulnerable to intense rescue wishes or unresolved grief. The supervisor provides a place for nonjudgmental exploration of the home visitor's feelings and responses. Supervision also teaches about interpersonal dynamics by helping the home visitor examine interactions between herself and her client, paying particular attention to the client's expectations and feelings about the relationship.

What Makes This Home-Visiting Program Work?

The Visiting Moms Program at MGH Chelsea HealthCare Center is effective because of the paraprofessional bicultural/multilingual home visitors who, with the close help of many professionals, compassionately offer emotional and concrete assistance to immigrant and refugee mothers, infants, and families. The program reduces the isolation of the mothers, acknowledges their special needs as newcomers to the United States, and supports optimal parenting of their very young children. The health center expects collaboration between medical, community health, and mental health staff. Community collaborators are also essential; resettlement agencies, child protective services, ESL programs, day care, and the schools all assist with the work of the home visitors to help reduce their clients' isolation and promote connection to the community. Such collaborations in client care offer great benefits to the families, but equally important, they are vital for the well-being of the home visitors.

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