CHAPTER 11

Mom2Mom

An Attachment-Based Home-Visiting Program for Mothers of Young Infants

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Mom2Mom (M2M) was born in 2000 as an innovative home-visiting project in Israel, aimed at providing emotional support to mothers in the year that follows childbirth. Home visitors are volunteers, trained and supervised by project coordinators who are professionals in the field of child development and social work. Basic tenets of the project are in keeping with attachment theory and with a broad literature that shows that mothers who are well supported by family, friends, and their community enjoy parenting more, feel better about themselves, are less likely to be anxious and depressed, and are more sensitive to their infants' needs. Furthermore, there is strong evidence that infants of these mothers develop more optimally, according to many outcome measures, including felt-security and resilience to stress. In this chapter, we describe the development and implementation of M2M. We outline its basic tenets, describe the processes that underlie the project (e.g., training, supervision, and evaluations), as well as our challenges, and our plans and dreams for the future. Our hope is that a description of the development of M2M will acquaint readers with the project. More generally, we hope that our account offers a general plan and tips for other professionals who are thinking about founding or those planning or already working on the same or similar projects. We consider the information worthy of sharing because, quite simply, the development plan has worked for us, for our home visitors, and for most of the families we have served.

The Past, Present, and Future of M2M

The M2M project is modeled after the Visiting Moms (Boston, Massachusetts) program (see Paris & Dubus, 2005; Paris, Gemborys, Kaufman, & Whitehill, 2007)—grounded in both attachment theory and a broad literature showing that emotional support during the months after childbirth can reduce mothers' stress level, counter loneliness and feelings of isolation, and encourage feelings of self-efficacy and self-esteem (Cutrona & Troutman, 1986; for meta-analysis, see Andresen & Telleen, 1992; for reviews, see Cobb, 1976; Hoffman, & Hatch, 1996). Importantly, the literature indicates that support, well-timed and well-tuned to mother and family, predicts more sensitive maternal behavior (Andresen & Telleen, 1992; Crockenberg, 1981) and mothers' greater resilience in the face of the challenges that may arise during the course of this period of profound transition (Dunkel Schetter, 2011). Consequently, efforts to support mothers during this time can benefit their children and family as a whole and therefore contribute to the future health and wealth of a culture and society (Harris, Lieberman, & Marans, 2007; Odgers, Caspi, Russell, Sampson, Arsenault, & Moffitt, 2012). In this regard, maternal emotional support may be especially important because stress, dangers, and uncertainty are often part of daily life, for example, as in many countries (like Israel) where war is a recent memory and peace is elusive, or in families anywhere that contend with serious internal dysfunction or a significant lack of personal or familial resources. M2M offers support to women during one of the most important periods in their lives and in the lives of their children. Moreover, M2M helps the helper to realize her own strengths, and harness them in an effort to provide support to a woman who just had a new baby.

M2M in Israel began in the year 2000 and as of 2015, has 25 branches (throughout the country), serving hundreds of families every year. We advertise in hospitals and well-baby clinics, and receive referrals from professionals (e.g., psychiatrists, family doctors) and concerned relatives and neighbors. About half of the women who join the project are self-referred. We work together with offices within municipalities, ministries (e.g., social services, health ministry) and special offices (immigration). We lobby in the Parliament; we put mothers in contact with needed resources that range from free baby equipment to a volunteer doula. We support mothers through difficult judicial proceedings (divorce, custody), help them reach out to social services, and connect them with psychological services, if needed. We have trained more than 250 volunteers (in Jerusalem alone) and paired them with more than 500 mothers for a year of home visiting. We run a weekly play group for mothers and infants up to age 1 year. The project is called *eml'em* in Hebrew (Mom2Mom, in English; website: *www.emlem.co.il*), and today is a well-known and well-used fixture in the Jerusalem landscape of resources for families.

What follows is select parts of our story, particularly those that may further understanding of our goals, steps toward implementation, and some of the underlying processes that have made M2M the success story that it is. We share the M2M history by drawing on a lifespan metaphor for becoming parents, starting with the "joining of hands" and continuing through "pregnancy/gestation" and the birth of the "infant." We discuss the development of M2M during the project's early years and compare that with its present status, which involves diverse, interlocking tiers

providing support to one another. Accordingly, our logo, representing our project, is drawn as concentric circles reflecting interlacing connections between coordinators and home visitors, between home visitors, between home visitors and "our moms" (the clients); and, at the center of it all, are the mothers and their babies. At the end of this chapter, we share our challenges and dreams.

A Historical Perspective: From Conception Onward

Joining Hands

Relationships are at the heart of the M2M model. At the inception of the project, two relationships were of crucial importance, and they have continued to be among the most important relationships that "we" have. One was between Marsha Kaitz and a former student Miriam Chriki, who practices as a developmental clinician in the field. Miriam has been a founding partner of M2M, and together with Kaitz, put the first "bricks" of the project into place. This relationship has been so important that we now suggest strongly that all persons considering the founding of M2M in their community find a partner (a passionate and committed confidante) as a first step on their "to-do list." The second relationship that is a solid cornerstone for the M2M project is with the Irving Harris Foundation based in Chicago, and with the Harris-funded Professional Development Network (PDN). The former has supported us financially and the latter, emotionally and academically from the start of the project.

Pregnancy: Defining Basic Tenets

At the outset (1999–2000), we were privileged to have time to plan the project, without pressure to "open our doors" right away. This period of gestation gave us the luxury of time to attend mindfully to the project's "needs," including careful consideration of focal aims, basic tenets, and core processes such as training, supervision, and evaluation—down to the fine details, including the project's name, logo, and color of the stationery.

Some of the important issues and decisions made at this stage are listed and described below.

Attachment Theory as Our Guide

Following Visiting Moms, we grounded our support project in attachment theory (Bowlby, 1969/1982), which means that our primary tenet is that secure relationships are essential for individuals' good health and development, especially in times of distress or transition. With attachment figures by their side (and secure representations "in their head"), individuals perceive themselves and others in a more positive light (Mikulincer & Shaver, 2016), are better able to regulate their emotions and behavior (Mikulincer, Shaver, & Pereg, 2003), and develop more optimally than persons who are not privy to attachment security (Raby, Lawler, Shlafer, Hesemeyer, Collins, & Sroufe, 2015).

For parents, a history of secure relationships makes it easier for them to open their hearts freely to their children, without fear, and respond consistently to their needs in a manner that balances sensitivity and appropriate demands (Karavasilis, Doyle, & Markiewicz, 2003). These parents also tend to perceive their children's motives and needs with reasonable accuracy (Haft & Slade, 1989), adjust their expectations and attention to fit their children's developmental level (Karavasilis et al., 2003), and are more likely to cope effectively with the significant challenges that often accompany the postpartum period (Mikulincer & Florian, 1998). Research indicates that parents with secure attachment enjoy parenting more (Slade, Belsky, Aber, & Phelps, 1999), seem to get along with their spouses better (Feeney, 2002; Hazan & Shaver, 1987), and have lower incidence rates of anxiety and depression before and after childbirth (Bifulco et al., 2004; McMahon, Trapolini, & Barnett, 2008). Importantly, children of parents who are securely attached, according to attachment assessment tools, are more sensitive and more positive with their children (Ainsworth, 1979; Slade et al., 1999; Wolff & van IJzendoorn, 1997), and are more likely to have children who are secure and well adjusted than parents who have an insecure (dismissing, preoccupied or unresolved regard to loss and/or trauma) pattern of attachment (Cowan, Cohn, Cowan, & Pearson, 1996; Fonagy, Steele, & Steele, 1991).

On these bases, M2M offers emotional support—a partner in the form of a volunteer home visitor from the community, who is also a mother—to share the lows and highs and uncertainties that are often part and parcel of the important first year after childbirth (Kaitz & Katzir, 2004). Attachment theory contends that partnering in this way can promote a secure emotional bond between individuals (Ainsworth, 1989). It is our hope that such a bond forms between mothers and volunteers, and that it helps mothers achieve their goal of being the best caregiver they can be and to cope with barriers that interfere with that aspiration. Furthermore, closely aligned theories, particularly relational regulation theory (RRT; Lakey & Orehek, 2011), stress the contribution of relationships and shared activities for regulation of the "recipient," which is exactly the nature of the supportive intervention offered by M2M (also see Heinicke, Ruth, Recchia, Guthrie, Rodning, & Fineman, 1999; Paris & Dubus, 2005; Paris et al., 2007; Stern, 1995; Slade, 2002).

Our anchor in attachment theory also prompts our continual efforts to nurture secure connections between home visitors and staff members. For this, we try to be available to home-visitors 24/7 by phone or e-mail, and to foster and reinforce a sense of belonging to the project as a whole. In these ways, we try to make the "job" of home visitor enjoyable, secure, and enriching, despite the difficult circumstances that some of our volunteers confront during their home visits. We also hope that through our efforts, volunteers feel secure enough to freely share their home-visiting experiences with coordinators and other volunteers during monthly group supervision sessions. In this way, group facilitators can help guide home visitors through dilemmas, contain their distress and uncertainties, help them to digest their experiences, and offer insights that may be helpful in the quest to forge a close relationship with "their mom." With trust in hand, volunteers can more effectively regulate themselves during home visits and successfully balance the need to "be present" and emotionally available to their mom, while maintaining personal space considerations and boundaries that are comfortable and appropriate for the

individual, place, and time (Cole, 2014; Hauer, ten Cate, Boscardin, Irby, Iobst, & O'Sullivan, 2014; Kaitz, Bar-Haim, Lehrer, & Grossman, 2004).

The focus on relationships extends to the circle of home visitors themselves. This is important, because volunteers' support of one another, through the sharing of feelings, experiences, and ideas, can be mutually regulating and lead to creative strategies for dealing with issues that arise during training and supervision. In one recent supervision session, a volunteer was down-hearted because her "mom" moved away without saying good-bye, leaving her feeling despondent and unable to "let go" of the case without closure. In supervision, the volunteer was able to find closure through open discussion of the challenges of separations and what she, personally, had gained, and what her "mom" had gained during their time together. Mutual support and working on shared goals also enhance feelings of closeness between the volunteers and remind them that they are part of a larger group and not alone in the field.

Finally, secure relationships between us, the coordinators, are paramount to the health of the project. Our mutual closeness and trust makes it possible for us at the helm to continue to work in the field with confidence, knowing that should we falter or fall, there is trusted help readily available. This prevents burnout, protects our mental and physical health, and endows the project with viability and strength that it might not otherwise have.

Free Services

The widely quoted line "It takes a village to raise a child" (Clinton, 1996) reflects the difficulty of going it alone as a family with young children and the universal need for support when rearing them. For some families, support is "built in" and members of the family gather round to provide the practical, informational, and emotional support needed in times of stress and transition, including the early months after childbirth. For other families, support is less or not accessible because of logistics, practicalities, interpersonal relations, history, and/or family culture. With this, we believe that regardless of where a family is positioned on the continuum of "support accessibility," mothers can benefit from a home visitor who is "there" for the sole purpose of supporting their efforts to be a good mother (Lakey & Orehek, 2011). Certainly, in families contending with significant difficulties and risk, weekly home visits that afford mothers the opportunity to "download" their feelings, sort them out, prioritize issues, and strategize can go far in helping them to feel better about themselves and move forward with confidence (Cohen & Willis, 1985).

On these bases, we hold close the tenet that all services related to M2M are provided free of charge. In addition, we train and supervise professionals and share our project-related materials (e.g., posters, flyers, and training tools) free of charge with those who want to start M2M in their community. Our only stipulations are that all services based on our material are provided to clients free of charge and that the staff members of the new project attend our training course. The rule of free services is important to us, because we do not want M2M to be a business, but rather a community-based project developed out of need and dependent on the good will of dedicated volunteers who want to help mothers, infants, and families.

Most importantly, our provision of free services assures us that, within the M2M network, money will not come between a family's need and the support we offer.

Home Visitors from the Community

These tenets are shared with the Boston-based project Visiting Moms (also see Donovan, 2011), but set us apart from most home-visiting projects for mothers of young infants, which typically use salaried professionals as home visitors (e.g., Goldblatt, Yahav, & Ricon, 2014; see meta-analyses in Drummond, Weir, & Kysela, 2002; Olds, Sadler, & Kitzman, 2007; Sweet & Appelbaum, 2004; see reviews in Segal, Opie, & Dalziel, 2012). To our way of thinking, the idea of neighborhood women visiting other women in their community after childbirth for up to a year is appropriate given that our primary goal is to support mothers emotionally, and to accomplish that, the women need quality time together to build a relationship (also see Landy, Jack, Wahoush, Sheehan, & MacMillan, 2012). Our basic assumption is that the close relationship forged between home visitor and mother is the mediator—the underlying foundation—of successful home visits (Landy et al., 2012; Watkins & Riggs, 2012), defined in our evaluations by mothers' ratings of satisfaction with the project, and what and how much they gained from it.

Focus on Mothers of Young Infants (0–1 Year of Age)

The decision to focus on families with infants under age 1 was based on several considerations. First, the first year after childbirth is considered a particularly important period in children's development because of the substantial neural/brain growth and pruning that occur during this time and the strong impact that infants' early experiences have on their "present" and future development (Bell & Fox, 1994; Fox, Levitt, & Nelson, 2010). Second, we know that the first year of life is the time when mothers and infants get to know each other and, through their mutual, dynamic social interactions, come to forge an attachment relationship (Ainsworth, Blehar, Waters, & Wall, 1978/2014). According to attachment theory, mothers' early responses to their infants' distress signals play a significant role in determining whether infants develop a secure bond with their caregiver as a result of consistent and sensitive caregiving or an insecure bond due to maternal behavior that is ill tuned, inconsistent, and/or frightening to the child (Ainsworth, 1979; Bowlby, 1969/1982; Isabella, 1993). Third, the first postpartum year is one of transition and challenge for parents, so that extra support can be particularly beneficial at this time (Cowan & Cowan, 1995).

Nesting: Getting Ready

Defining our identity entailed setting criteria for accepting women into the program as volunteers and clients, though we have kept such rules to a minimum in order to welcome a broad spectrum of participants. To be a volunteer, the only criterion is to be a mother with free time for home visiting (2 hours a week) and supervision (2 hours a month). The criterion of being a mother seemed important for sharing experiences during training and supervision, but mostly because we

reasoned that mothers seeking support after childbirth are likely to see a woman who is herself a mother as a viable "partner," mentor, or friend. As for the clients, almost all are accepted, with the exception of extreme cases in which there is violence or abuse of hard drugs in the immediate family. This rule was put into place in order to protect the volunteers from circumstances that are potentially dangerous and beyond what they can handle. Finally, we decided to prioritize cases on a first come, first serve basis, with some flexibility to accommodate cases that are in need of immediate help. This decision was based on our wish to avoid ranking the (espoused) needs of mothers who have asked us to help them.

Toward our opening, we readied core processes, including training, supervision, and evaluation. We also prepared the organizational material we would need in the course of running the project, so that we would be ready to start training, matching, pairing, and supervising as soon as we opened our doors. This material included succinct and catchy abstracts to distribute to professionals and laypersons, a manual to accompany the training sessions, advertising material (e.g., posters and flyers, business cards, budget spreadsheets) and questionnaires used to obtain participants' evaluations of the project. Of especial importance was the creation of the spreadsheet endearingly called "the demo," which essentially tracks each mom and volunteer and also lists their contact information for easy access. Also essential was the creation of a Statistical Package for the Social Sciences (SPSS) file into which we enter data related to participants' demographics, dates of beginning and end of visits, feedback gleaned from evaluation forms, presenting problems, family and personal risk factors (e.g., mothers' health issues), and availability of other sources of support, among other information. This file and "the demo" are updated at least weekly and are the basis of analyses reported here.

As a final step in our planning stage, we organized a brunch for the heads of family-centered projects in the city. This was our way of thanking those who had helped us in our planning stage, of introducing ourselves to professionals in the community whom we had not yet met, and for transmitting our desire to network and work together toward a common goal of helping families. The connections made in that forum were important ones, and they have remained strong over time despite changes in personnel. The brunch also was a good way to celebrate the end of our planning stage and begin the next stage of implementation.

The Birth

Encouraged and ready, we opened our doors to a sliver and enlisted good friends, whom we asked to be our first home visitors. The locale of training was the home of the first author (M. K.), and we trained around the kitchen table. Then, with processes in place and our first volunteers trained and waiting, we began to advertise the project in community papers, well-baby clinics, and hospitals in the area. Referrals began to roll in; mothers called, and we were officially off and running. M. K. took the first mother and M. C. took the second, then subsequent referrals were matched with the other volunteers. In short order, we hired a student to man the phone lines and enter data into "the demo" and SPSS file. We began to train on a regular basis, provide supervision, and reach out to a wider circle of resources. We gained recognition by giving interviews to the media that had regarded our project,

since its inception, as a *nice* one that can temper turmoil that often marks news of daily life in Israel.

At this point in time, we also found another "home" in which to train and run supervision groups. For this, we connected with the municipality that offered us rooms, free of charge, in a community center in the middle of town. The office and phone lines of M2M were and still are located in M. K.'s lab in Hebrew University, so that research assistants and M2M staff share facilities, thus affording the two teams opportunities to learn from each other. The sharing of space has enabled cross talk between students and staff working on varied projects, and this has enriched the experience for all. Notably, Hebrew University administers the financial end of M2M, for the price of "overhead," and this allows the project to be a tax writeoff for donors.

"Postpartum"

As our reputation as a quality project has spread, requests from professionals to disseminate the project to areas outside Jerusalem have burgeoned. In response, we have written up a "to-do" manual that describes the initial steps to set up a branch of M2M and designed a training and supervision protocol to help new directors get the project off of the ground. We now have branches of M2M and offshoots (e.g., mothers' support groups, play groups) in cities and communities throughout Israel. Some of the branches are integral parts of municipal services; others are located in community centers or universities. What they have in common is that the head of the project and/or the staff members were trained by us, or by professionals trained by us; the projects aim to support mothers with young infants; and their services are provided free of charge.

The expansion of M2M sites allows directors and staff members of the different projects to work as a network—passing on volunteers and moms to the most fitting locale, and sharing knowledge and skills. We also share our experience and expertise with directors and personnel of other family-centered projects and institutions. Shared activities include giving lectures and seminars on the project and its development. In addition, students from the Hebrew University, the Open University, David Yellin College, and Bar Ilan University have received academic credit for their participation in the project or for their use of M2M data for seminar papers or theses.

Processes and Implementation

Intakes

Intakes constitute the first face-to-face meeting that coordinators have with volunteers and mothers who have requested support from the project. The meetings are usually one-on-one and take place in the mother's or volunteer's home. Intakes provide coordinators with the opportunity to explain the project to potential participants and to begin to get to know them and for them to get to know us. Intakes of mothers are aimed at explaining the goals of M2M and the "mandate" of volunteers.

The coordinators also can use the time to assess the safety of the home venue for the volunteer and home visiting. During intakes, mothers are asked pointed questions about their needs, what they would like to gain from the project, and their preferences for a volunteer. Those women who are interested in joining the project provide demographic information as well the name and number of professionals (social workers, psychiatrists), who are in contact with them "at present." In most cases, we contact the professionals to say that we are "in the picture," but mostly we keep the information on file in case of a crisis that is beyond the capability of M2M to deal with (e.g., sudden homelessness, psychotic breakdown, threat of or actual violence in the home). For volunteers, the intake is done before training, and is the start of what we hope will be a long lasting relationship with M2M. The intake provides the volunteers with an opportunity to talk freely about themselves and to tell us why they want to volunteer in M2M. For both mothers and volunteers, intakes are the gateway to the project, and we use them to reduce participants' anxieties by answering questions candidly so that training (for volunteers) and home visiting (for mothers and volunteers) can start out on the right foot.

Training

The primary aims of training are to become familiar with M2M, to bond with the project, to develop a relationship with staff members and other volunteers, to reflect on processes that make relationships happen, and to practice home-visiting skills. For these purposes, the course is highly interactive and, practically speaking, it is 8 hours long, scheduled 2 hours per session, for 4 consecutive weeks, with the participation of four to eight volunteers in each group. Days and times of the course are scheduled according to preferences of the participants, with most scheduled during evening hours (20:00–22:00) to accommodate volunteers who work full time and those who have young children. A training booklet accompanies the course and is used as a reference during training and home visiting.

The course introduces the program and personnel to the volunteers and takes them through first contacts with a mother seeking support, solving problems *with* the mother and not *for* the mother, and finally teaches some observational skills. Specifically, the first session introduces coordinators to the new volunteers and the volunteers to each other, to the coordinators, and to the project as a whole. To facilitate this, we ask volunteers to share an experience that they had in the months that followed the birth of one of their children, and then we talk about sources of support that were particularly helpful to them at that time. This exercise is a good start to getting acquainted, prompts a discussion of the meaning of support, and raises questions as to what makes for effective support and why it is so important for our well-being. It also "ups" the intimacy level between volunteers. In the first session, we also facilitate an exercise that demands active listening (without speaking), which affords participants a chance to practice *really* listening to another person, which is central to their home-visiting job. This listening task involves pairing up volunteers and given each member of the pair 2 minutes to speak, without the other speaking at all, though the other can express emotions through nonverbal cues. Then they switch roles. Volunteers are surprised that refraining from speaking promotes real listening. Some are quite challenged during their "quiet time," and

this can be a powerful experience for them. The second training session focuses on the volunteer's first phone call to the mom in which she introduces herself and negotiates a time and day for their first meeting. Volunteers also role-play a first visit with a mom, so that they can practice and acclimate to their role. We spend time on these introductory meetings, because first impressions can be lasting ones (Bar, 2007; Bar, Neta, & Linz, 2006), and it is important for the "pair" to get off on the right foot, so to speak. At the third session, we talk about stress and present a model for solving problems *with* someone instead of *for* the person. The volunteers then practice using the method in interactive exercises with structured scenarios that might arise in real life. Using these exercises, among others, volunteers can practice their role as a home visitor, reflect on their feelings, and receive feedback from their trainer and other volunteers. The fourth and final session focuses on social cues that help us get to know another person. For this, we watch video clips of mother–child play interactions in an effort to hone observational skills and learn about features of interactions, such as the synchrony and shared affect that predict secure attachment and healthy development. Finally, we discuss "barriers to home visiting" such as the ones listed in Table 11.1.

As in the Boston-based project, our training sessions are facilitated by the project coordinators. We all attend the first session; the other sessions are split among us. This roster is important, because it affords each coordinator ample opportunity to get to know the new volunteers, which is imperative for being able to effectively match them with a client after training. Likewise, the roster offers the volunteers opportunities to get acquainted with the staff members, which is an essential first step for bonding with us and with the project. To nurture these connections, we take special care to transmit our thankfulness to the volunteers for their participation

TABLE 11.1. Barriers to Home Visiting and a Sample of Issues Discussed in Supervision

Barriers from volunteers and moms
1. Difficulties in maintaining comfortable and appropriate personal borders
2. Bad match
3. Clash of values between volunteer and client
4. Personal issues interfere with the home-visiting schedule and emotional availability
5. Interpersonal style
Barriers from moms
6. Client's lack of commitment
7. Problem trusting others
8. Difficulties in focusing on relevant Mom2Mom issues
Barriers from volunteers
9. Espousing solutions
10. Frustration at no or slow progress
11. Unclear why mother needs Mom2Mom support

both in our words and actions. We encourage interactions between volunteers, so that they will get to know each other and form a relationship between themselves. In the end, we hope that the group meetings are demonstrations that no special skills are necessary to forge ties with another. Availability, sensitivity, consistency, and mindfulness are the keys.

Supervision

Supervision in M2M is "reflective," which means that the sessions provide a secure base in which volunteers can step back from their field experiences and take time to process them (Gikerson, 2004). Through reflection, volunteers can assess their own performance and become aware of their strengths, limits, and vulnerabilities, which in turn promotes realistic and effective strategic decisions regarding the directions that they should take to help the mother they visit (Ruch, 2005). Reflection also prompts volunteers to consider the mother's perspective of her own life and the reason that she turned to M2M. In this way, the volunteer can speak to her mom on the mother's own terms, from her own belief system and principles, without judgment; and this fosters sensitive responsiveness on the part of the volunteer and trust on the part of the mother who is seeking support.

We consider a well-functioning supervision group to be one whose members work as a team to support each participant's feelings about the work and the issues that arise. As a team, the participants work to identify appropriate next steps, empathize with difficulties, and rejoice in each other's successes. The role of the supervisor in this process is to help the supervisees answer their own questions and to provide the support and knowledge necessary to guide healthy decision making. The issues listed in Table 11.1 are among the important themes that are discussed thoroughly and frequently revisited in supervision sessions. During these discussions, the supervisor serves as an empathetic and nonjudgmental sounding board for the supervisees, in the hope that they will provide the same to each other. Working through complex emotions in a "safe place" allows the supervisees to freely explore their feelings, and the security derived from the relationship with the supervisor and the group as a whole can reduce stress in the field (Bennett & Saks, 2006; Pistole & Watkins, 1995; Watkins, 1995; see review in Watkins & Riggs, 2012). It also allows the supervisees to experience the same sort of relationship that we hope they will nurture with the mothers they visit (also see Jarrett & Barlow, 2014). Supervisors also support home visitors by using supervisory meetings as opportunities to acquire new knowledge. One way of doing this is to encourage supervisees to analyze their own work and its implications. Another way is to discuss topics associated with home visiting that can enrich the volunteers' knowledge base and experiences (e.g., new applications of attachment theory to clinical endeavors, new therapeutic advances, and relevant research findings about children and development). Practically speaking, monthly group supervision is required of all home visitors in our project, and to encourage attendance, we offer supervision on several days, at several times, and in a locale that is easy to reach by public transportation. If, despite this, a volunteer cannot make a session, supervision may take the form of a phone or private meeting, so that, at the very least, the coordinators receive an update, and volunteers can download their feelings.

Staff Meetings

For many years, M2M staff meetings have been held once a week, at the same time and in the same place (a university office). The primary goal of the meetings is to assign mothers who have called or were referred in the past week to the coordinators; match mothers with volunteers, and split between us whatever other tasks are on the agenda. Such tasks might include meeting with professionals who are interested in starting a project in their place of work or in their community, advising a student who seeks consultation about a study or thesis, or the planning of peripheral activities such as our coming roundtable meeting that is aimed at gathering together heads of family-centered projects in Jerusalem for networking and strategic planning. Once or twice a year, the coordinators plan a special staff meeting to consider new processes or revisit old ones that need to be revised.

Staff meetings, like supervision and training, are reflective. We reflect on ourselves and our feelings regarding any aspects of the project or our lives that seem relevant or worthy of mention. At least 15 minutes are devoted to talking about our personal lives, which draws us close and keeps us informed.

Matching

The coordinators agree that the most fun part of our work is matching moms with volunteers. Likely, this is because the addition of a new pair to our "active list" marks the end of a long process that began with the mother's call, followed by an intake in the mom's home, the search for and negotiations with a volunteer, and the OK from both mother and volunteer to give it a try. Hope is inherent in the process: hope that the pair will work, hope that it is a new beginning of a close relationship, and hope that volunteer and mother will gain from participation in the project and their time together.

Matching is not a simple process, because it takes into account many complex factors, some related to logistics and others that have to do with the individuals themselves and their life stories. Logistics are the easy part, and the general rule is to try to pair women who live close to each other, so that the volunteers do not waste time on the road. This is not only important for our volunteers who depend on public transportation, but it also is true for those with cars, since time is precious and we do not pay for gas or auto upkeep. With this, some clients may voice concerns about working with a volunteer from their neighborhood, because they may have common friends and would feel uncomfortable running into each other outside of the home-visiting context. Other requests may include a preference for a volunteer with a similar belief system (religiosity), because it relates to so many important and basic issues inside and outside the home, including dietary restrictions and the style of clothes deemed appropriate for wearing in public. Women also may have a certain age range in mind for their volunteer, particularly if they are seeking a mother figure or a friend who is a young mother herself. Language also is an issue, since some of the mothers in the program are new immigrants who want a home visitor who speaks their mother tongue. In all cases, we try to match women who we think will "dance" well together—either because their speed,

tempo, and rhythm are the same or complementary or, in keeping with the analogy, because they know or like the same "music."

It should be noted here that sometimes we intuitively feel that a match is a good one, and sometimes we are less than sure, even though it is the best option that we have available. In the latter circumstance, we make the match with some trepidation but hold firm to the belief that a bond will form between volunteer and mother if visiting conditions are right (consistency, openness to the relationship, sensitivity, mindfulness), and if they both want it to happen. By the same token, a seemingly excellent match can go wayward, if conditions do not foster a close relationship between visitor and mom. This can happen for many reasons, most frequently because the mother is not emotionally ready or able to work on nurturing *another* new relationship (besides the one with her infant) or she cannot commit to weekly visits because of her busy schedule, or because commitment is generally difficult for her or she feels that she cannot focus on her emotional needs because the challenges she is facing are too overwhelming. Sometimes, these mothers reconsider; other times they do not. Sometimes they miss the opportunity with their first child but join after the birth of their second.

Evaluations

Evaluations of our project take three forms. The first comprises case reports of mothers who joined the project. These case reports illustrate the processes by which gains are made within the framework of M2M and help identify factors that may interfere with the development of a relationship between mom and volunteer. The second means of evaluation is based on empirical data reflecting our progress, including a tally of total intakes, matches, and volunteers trained each year. The third method of evaluation is based on data derived from feedback of mothers and volunteers on the questionnaire that we administer at the end of the visiting period. The questionnaire has three parts. One part assesses mothers' global satisfaction with the project and is calculated as the mean of ratings on two scales (rating 1 for low to 5 for high): (1) Are you glad that you joined the project? and (2) Would you recommend the project to someone else? The second part of the questionnaire taps mothers' perception of the closeness of the relationship between volunteer and mother, and it is derived by averaging mothers' ratings (1 for none to 5 for a great deal) on four items: (1) intimacy of the relationship with the volunteer, (2) fit of match with volunteer, (3) difficulty in separating from the volunteer, and (4) "closeness" between volunteer and mom (Cronbach's alpha = .85). The third and final part of the questionnaire comprises 14 rating scales (1 for none to 5 for a great deal) referring to potential gains (e.g., increased self-confidence) resulting from the home-visiting experience. From these scales, a measure of Overall Gains is derived, and for more detail, measures of Gains on two internally consistent factors: Personal Gains (e.g., mood, confidence) and Gains in Child Care and Child Understanding (e.g., valuing the infant more). All three measures of Gains are derived by calculating the average score across relevant items. All Gain items are listed in Table 11.2. For presentation, we have collapsed the 5-point Gain scales into 3-point scales (rating 1–2, 3, 4–5) because of the low counts in some of the cells. In all, the

aim of these three modes of evaluation is to derive empirical data on (1) what mothers gain from the project, (2) whether the mothers are generally satisfied with the project, and (3) whether mothers' feelings of closeness with their volunteer predict mothers' satisfaction and their gains.

Analyses of the data (N = 226; 40% of the total) suggest that, overall, mothers are very satisfied with the project (mean rating = 4.61, SD = .92) and develop a close relationship with their home visitor (mean rating = 3.95, SD = .75) Furthermore, the women who filled out the questionnaire reported moderate to strong "gains" across 14 domains (see Table 11.2). According to mean ratings, the most notable gains are in terms of feeling less isolated and more positive. Interestingly, items having to do with self (bold, in Table 11.2) were rated higher than the ratings of gains on items related to their infant: mean, SD: 3.67, 1.11 vs. 3.11, 1.31, respectively; repeated measures general linear model, $F(1, 225) = 63.22$, $p = .001$. This latter finding may be related to the fact that a substantial proportion (39.7%) of participants were multiparae and therefore, already highly experienced in caregiving before they joined the project.

TABLE 11.2. Gain Items Listed on Evaluation Forms, Mean Ratings of Each One, and Percent of the Sample That Rated Each Item as Low (Rating 1–2), Moderate (Rating 3), or High (Rating 4–5)

		Percent mothers (N = 226)		
Gains from M2M	**Mean**	**Low**	**Moderate**	**High**
Feel less isolated	**3.99 (1.23)**	**5.3**	**25.3**	**73.7**
Be more positive	**3.98 (1.24)**	**6.6**	**19.8**	**73.2**
Comfort with feelings	**3.85 (1.30)**	**8.6**	**21.6**	**69.8**
Self-worth	**3.73 (1.37)**	**11.7**	**24.7**	**63.6**
Self-confidence	**3.68 (1.45)**	**14.5**	**20.6**	**64.8**
Get out of the house	**3.44 (1.53)**	**17.4**	**26.8**	**55.7**
Reduce anxiety	**3.41 (1.42)**	**15.7**	**28.3**	**57.1**
Solve problems	**3.43 (1.33)**	**11.9**	**31.0**	**56.4**
Trust others	**3.12 (1.43)**	**21.0**	**31.1**	**47.9**
Meet infant's needs	3.09 (1.51)	24.6	28.3	47.1
Value infant	3.06 (1.58)	27.3	27.3	45.5
Reach resources	**3.04 (1.69)**	**32.8**	**20.1**	**47.0**
Learn caregiving	3.03 (1.43)	22.0	37.1	40.9
Sensitivity to baby	2.94 (1.55)	30.9	25.9	43.2

Note. **Bold type** identifies items related to Self; regular type identifies items related to Infant.

As predicted, the relations between (scores reflecting) the closeness of the mother–volunteer relationship and mothers' satisfaction and gains were highly significant: Spearman r's = .49, p = .0001; .58, p = .0001, respectively. These findings are important for us, because they examined a basic tenet of the project, which states that the benefits that mothers derive from the project are related to the support garnered from the relationship with their volunteer.

Together, our evaluative data suggest that mothers benefit from the M2M, mostly in the extent to which they see themselves in a positive light. The data also are consistent with the contention that M2M is attachment-based and, accordingly, that the benefits procured by mothers are related to forging a close and secure relationship with their volunteer.

From the beginning of the project, we accumulated evaluative data, because it was important for us to receive immediate feedback about the project. We chose the format, reasoning that questions that directly probed women's satisfaction with and benefits derived from the project were the most efficient route to take at that time. Though a more sophisticated approach using a randomized control design (Concato, Shah, & Horwitz, 2000) and a broader spectrum of outcome measures, including symptoms of depression, maternal behavioral sensitivity, and stress, would be very informative, the questionnaire that that we have relied on until now is within our budget, has content validity, and offers insight into our efficacy in running the project and the benefits that women derive from it (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). It also is within our budget.

Annual Data, Diversity, and Dissemination

According to our annual data, there has been a steady accumulation of referrals and training groups over the years. These data are presented visually in Figure 11.1 (A and B), and they reflect a "caseload" of 30–40 pairs in the field at any given time, with another 5–15 in various stages of the matching and pairing process. At present, this load represents the maximum that the project can handle given its staff and resources, and still provide quality supervision and backup for volunteers in the field.

Table 11.3, showing the demographics of a sample of mothers (N = 567) and volunteers (N = 235) who have participated in the project since 2000, indicates that it is used by a broad spectrum of women. In this regard, 11.7% of the mothers and 11.0% of the volunteers described themselves as ultraorthodox. This is impressive because members of that sector tend to isolate themselves from the general population and, if they volunteer, tend to do so within their own community. We also point out the high proportion (12.0%) of young volunteers (ages 20–29 years), most with young children, and the significant proportion (25.3%) of volunteers who work full time. More than half of mothers and volunteers were born in Israel; the others were immigrants from all over the world (North America, South America, West Europe, East Europe, Russia and the USSR, Australia and New Zealand, Eastern Asia, West Africa, South Africa). Sixty-one percent of the women who have used us for support were first-time mothers, and, across the sample, parity ranged from 1 to 14.

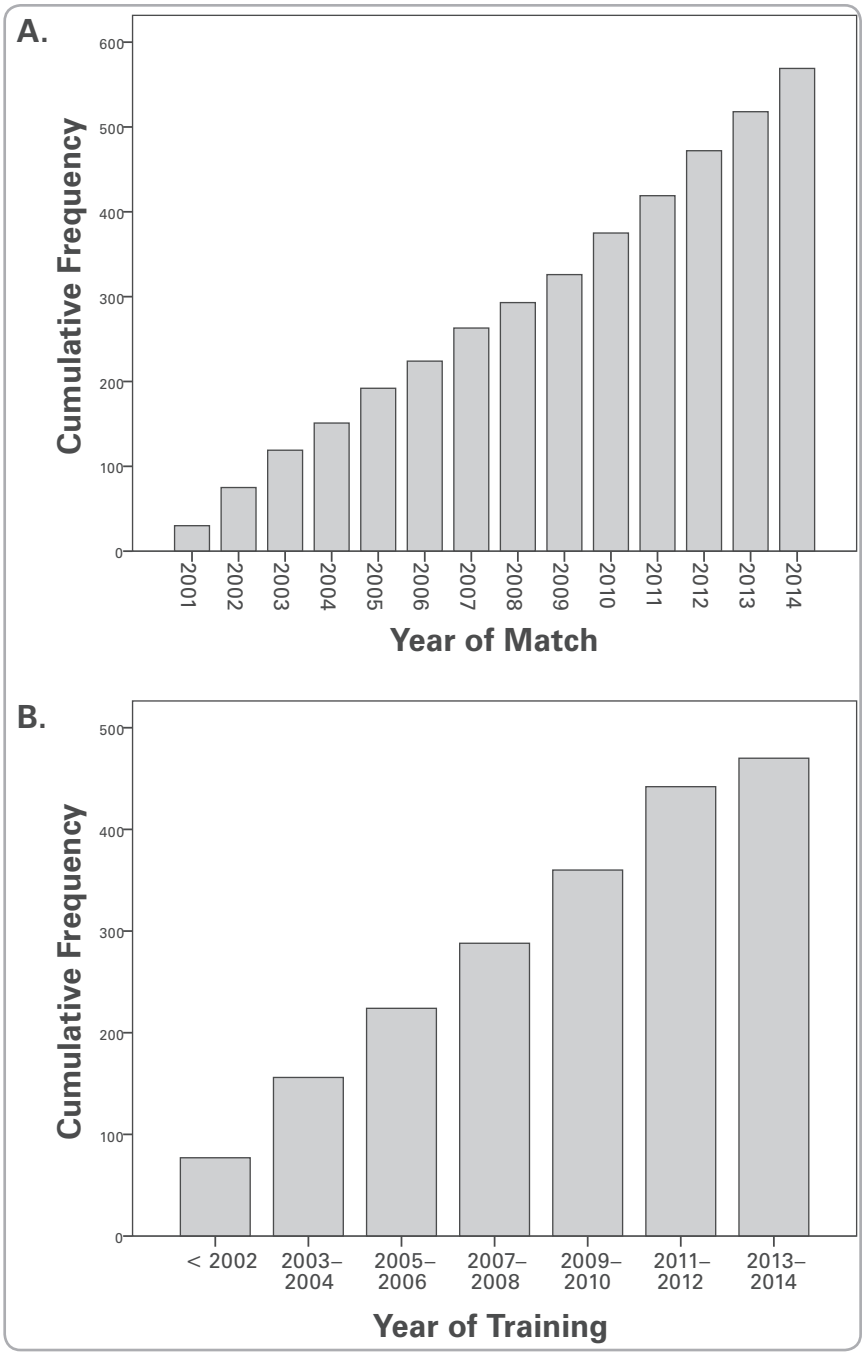

FIGURE 11.1. (A) Cumulative frequency of pairs in the field. (B) Cumulative frequency of training groups.

TABLE 11.3. Select Demographics of Volunteers (*N* = 225) and Mothers (*N* = 567) in the Program

	Volunteers	Mothers
Age		
Mean	44.38	32.86
Range	21–78	18–56
< 20	0	1.2
20–29	12.0	34.3
30–39	31.3	47.3
40–59	17.2	17.1
60+	39.5	0.0
Education		
< High school	0	1.7
High school	8.0	14.9
Professional training	17.3	17.5
BA	47.3	27.1
Graduate	27.4	17.1
No. of children		
Mean	3.12	1.63
Range	1–14	1–14
1	14.9	61.3
2–4	57.4	33.7
4–6	22.1	3.7
6 +	5.5	1.4
Family status		
Married/cohabitating	86.4	76.5
Single/divorced/widowed	13.6	23.5
Religiosity		
Secular (Jewish, non-Jew)	34.9	32.7
Religious/traditional	54.1	55.6
Ultra-Orthodox	11.0	11.7
Occupation		
Housewife	3.3	3.6
Health related	21.1	10.3
Clerk, secretary	17.4	27.7
Teacher	25.4	24.1
Academic, lawyer	9.4	13.9
Independent, student	10.8	13.3
Police, army	0.9	1.0
Social services	11.3	5.1
Manual labor	0.5	1.0
Work status[a]		
Unsalaried/retired/mat	39.3	40.0
Work time		
Part time	35.4	16.5
Full time	25.3	43.5
Immigrants		
Non-natives	45.7	39.4

[a]Work status at the time of intake, includes maternity leave (mat).

Diversity also is seen in the presenting issues of the mothers who join the project. As noted in Table 11.4, nearly one-fourth of mothers were single at the time of enrollment, and nearly one-third had mental health problems, according to the mothers themselves or the professional who referred them. Approximately one-third (35.2%) were listed as recipients of social services from the Department of Social Welfare. Also notable is the high prevalence of pregnancies induced after fertility treatments (7.3%) and the percentage of women with twins, triplets, or quadruplets (9.0%).

We also mention that most (64.1%) of our volunteers take on one mom after another, which, we believe, speaks to the meaningfulness of their home-visiting experience. In fact, 22.2% of volunteers have taken on two mothers in succession; 11.6% have taken on three; and 21.3% have taken on four to nine.

Figure 11.2 shows the number of branches founded in the country until now, including four branches located in and around Jerusalem (Modiin, Maale Adumim, Mate Binyamin, and the central headquarters in the center of the city). Besides these, there are 10 branches in the center of the country, five in the south, and eight in the north. Notably, some of the branches are considered "cousins" rather than offspring, as they were direct products of a training course for coordinators, offered in Oranim College, under the supervision of Daphna Noyman, MSW. At present, four new branches of M2M are in various stages of development and not yet marked on the map (Figure 11.2).

Challenges

There are many challenges in our work. Some of them are related to inherent features of the project, for instance, issues related to the fact that our home visitors are community-based volunteer mothers (also see Hiatt, Sampson, & Baird, 1997). Others are acute problems, for example, having to do with a particularly difficult case or a problematic mother–volunteer pair. A third category of challenges has to do with the administration and management of the project. We discuss here a few of the leading challenges.

TABLE 11.4. Issues Raised during Intakes of Mothers and Their Prevalence in the Sample ($N = 567$)

1. Isolation/loneliness	66.5%
2. Poverty	50.9%
3. Pregnancy complications[a]	35.8%
4. Mothers' mental health	31.7%
6. Infants' health (postpartum)	18.1%
7. Mothers' physical health	10.0%

Note. More than one issue could be listed for each mother.

[a]Includes *in vitro* fertilization, multiple fetuses.

FIGURE 11.2. Branches of Mom2Mom as of January 2015. From Google.

Volunteer Home Visitors

Using volunteer home visitors means that we cannot demand work-hours, but rather depend on the volunteers to understand the necessity of meeting frequently and regularly with their moms in order to develop their relationship. Volunteers take vacations, have family obligations, and change work schedules; and these or other time-limiting factors can interfere with the home-visiting schedule, which can degrade the volunteer–mother relationship and sometimes stymie it altogether. Volunteers may take incidents personally, become dysregulated by their moms' distress, become frustrated by a lack of progress, and may find themselves at a loss as what to do and how to do it in order to help the mothers they visit (see Table 11.1). For all this, the staff members need to be available to the volunteers, supervise them, and monitor the progress of visits carefully. For their part, the volunteers need to trust that the staff members are there for them and use them as a source of support and backup as needed.

Related to these issues are problems that arise because some volunteers are more difficult to train than others. This is sometimes because of volunteers' tendency to act first and reflect later, or because their interpersonal style is more authoritarian than the style that we encourage (Hiatt et al., 1997). Difficulties also may be related to the volunteers' own insecure attachment style, as noted by others (Pistole & Watkins, 1995). Though role playing, feedback, supervision, and exercises

in reflection go far in demonstrating "another way," old habits are often difficult to break, and coordinators can find themselves repeatedly trying to nurture a more relationship-based stance in some volunteers, with varying degrees of success.

Similarly, we find that some volunteers are easier to match to a mom than others (also see Lutz & Lakey, 2001). Again, this could be due to their interpersonal style (Hiatt et al., 1997) or because of logistical issues, such as the volunteer's limited free time. In addition, we are very careful not to pair volunteers with particularly difficult cases if they themselves are dealing with considerable challenges in their own lives. By the same token, some volunteers specifically request mothers with complex histories and circumstances, because they want to be absolutely certain why they are "there." For these reasons and others, it can take weeks to find a good match for a particular volunteer, and during that time, she may become disappointed, angry, or sad that she has not been matched as quickly as she thought she would be. In this context, we also mention special challenges in training and supervising volunteers who are themselves professionals who work with families in their day jobs (e.g., doctors, social workers, psychologists), because their habits of dealing with "cases" may be more directive then the kind of support that we offer in M2M. Helping these volunteers to make a shift in their heads and behavior toward a more relationship-based and reflective style during home visits is not always easy. Nonetheless, it is our hope that the experiences these professionals gain in M2M will enhance their professionalism both within and outside the home-visiting project, and the feedback that we receive from these professionals suggests that it does.

Mothers/Clients

Another set of challenges centers on the moms (i.e., the clients), who, by definition, have an infant under the age of 1. Given the exhaustion and workload associated with caregiving for a young infant, it can be difficult for our mothers to focus on feelings or to consider their own emotional needs, especially if they are dealing with entrenched and multiple problems in their lives. Not a few mothers in the project have had trouble committing to the home-visiting relationship because they have issues with trust. We also know well that mental health issues, and sometimes the side effects of medication, may challenge mothers' ability to commit to home visits and to participate in building a relationship with their home visitor. Mothers may overstep bounds and ask their volunteer to do chores or share in other activities that are outside of the home-visiting mandate, and this can put volunteers in a difficult position; furthermore, a negative response by the volunteer to the mothers' request can undermine and derail their relationship, especially if it is a new pair at the start of their "journey" together.

Administration and Management

Other challenges have to do with administration and management of the project. The two biggest challenges in these domains are budgetary restrictions and the constant attempt to balance quality and quantity. In this context, *quality* is defined as the degree to which M2M serves as a reliable source of support for mothers with young infants and succeeds in helping mothers to feel better about themselves,

bond with their infant, and be better able to cope with the issues that they are facing. *Quantity* is defined as the number of training groups that we are running, the number of active pairs in the field, and the breadth of related activities in which we are involved. As caregivers of the project, we are cognizant of the fact that an imbalance (quantity > quality) can mean that we are spread too thin, which makes quality supervision difficult and may cause time delays in our responses to questions or problems that may arise in the field. With all that, it is very difficult to limit the size of the project, because that entails refusing women who call us for help.

Future Plans and Dreams

Networking and expansion are the focus of our future plans. In this section, we describe some of these plans and also our dreams, roughly ordered from the ones that are in process and require relatively small modifications in the structure or content of M2M to those that we dream of and that entail more substantial change.

Plans that are in progress include expanding the window of home visiting, so that it extends to the antenatal period. This modification is being implemented because the antenatal period can be an anxious time for women (Kaitz & Katzir, 2004), and beginning home visiting then would offer them a time for mindful contemplation, guided and supported by their volunteer. Furthermore, a volunteer's presence and help from the start of the transition period, including childbirth, is a wonderful way to begin the mom–volunteer relationship, as we have seen in a number of pairs that began prior to delivery. This change in the time frame for home visits requires expanding outreach to professionals who care for women during pregnancy and to places that women frequent during pregnancy (e.g., antenatal ultrasound clinics). The expansion also requires some modification in the supervision and training of volunteers, due to differences in the content and structure of the home visits before and after the infant is born, although the fundamental aims, themes, and strategies of the project would remain the same.

At this time, we also are expanding services offered to clients in M2M by incorporating new and evidence-based intervention models for parents with specific challenges. For this, three coordinators (J. T., J. L., and M. K.) are being trained in Fussy Baby©, created by Professor Linda Gilkerson from Erikson Institute in Chicago, which is geared to parents with colicky and otherwise difficult babies (Gilkerson et al., 2012). One coordinator (M. C.) has been trained in child–parent psychotherapy (CPP), created by Selma Fraiberg in the 1970s and adapted by Professors Alicia Lieberman and Patricia Van Horn from University of California San Francisco, for treatment of persons with a history of trauma (Lieberman & Van Horn, 2005, 2008; see Toth, Michl-Petzing, Guild, & Lieberman, Chapter 13, this volume). A central goal of both models is to support and strengthen caregiver–child relationships and protect or restore mothers' and children's mental health. Also, both models center on processes of mindful reflection, so that their approaches are very much aligned with those of M2M. With the aid of our expanded repertoire of tools, we already are providing some clients in M2M with specialized short-term interventions, in addition to those offered by regular home visiting. For mothers with a history of trauma, we hope that a brief exposure to CPP within M2M will motivate them to

seek long-term therapy outside of the project, and we do what we can to see that this happens.

We also mention plans to improve and expand on our strategy for evaluation. Most important for this will be our careful consideration of the outcomes to assess and the methods by which to assess them. At present, our nominations for outcomes fall within two time windows: just after home visiting and a year later, to assess the stability of skills and state (well-being) of mother and child. At the first time point, we would continue to assess gains of mothers by subjective reports but would add objective indices, such as the degree of order in the household, as assessed by the Home Observation for Measurement of the Environment (HOME) questionnaire (Caldwell & Bradley, 1979), and maternal sensitivity, as observed during caregiving or structured or free-play mother–infant interactions, using one of the available Maternal Sensitivity Scales (e.g., Feldman, 1998).

For longer term outcomes, we would ask again about gains to determine whether they were sustained over time. We also would add indices that speak directly to infants' developmental outcomes, such as infants' self-regulation and physical health (e.g., Bayley, 2006). For all measures, we would utilize reliable and valid tools to assess them. In addition to these efforts, we need to find ways to up the percent return of the questionnaires so that our data reflect answers from a larger, representative sample. According to our analyses, women who filled out evaluations were more educated than those who did not, but they did not differ in age, marital status, or indices of risk (e.g., low socioeconomic status [SES], use of social services).

Closely aligned are plans to analyze in more detail the data collected so far. Such analyses could impart information on factors that contribute to the variation in Gains and Satisfaction of the mothers in the project and the conditions that make M2M most and least effective (see Weiss, Bloom, & Brock, 2014). They also could address more complex questions, such as whether mothers from high-risk families benefit more from the project if their home visitor is experienced and professional (i.e., works with families in her day job). On the one hand, high-risk families may find it difficult to trust a professional, if they have had uncomfortable dealings with social services in the past; on the other hand, a professional with experience may be more helpful to a family facing complex and difficult problems (Hiatt et al., 1997). These data would be informative to others who are involved in home-visiting projects, and publication of the findings would be a good means of disseminating information about M2M.

Also important at this time are plans for knitting our own M2M branches more closely together for mutual support and education. In this regard, we dream of adding a professional to the staff whose job would be to travel between branches, testing their efficacy and fidelity to the M2M model, networking, and providing backup and support to directors, as needed. Toward the same goals, we would like to bring the directors together for informative seminars and conferences as well as "play days," so that we can support each other, as the volunteers do for their moms, and as coordinators do for the volunteers. In effect, we would be adding a new dimension to our logo of concentric circles that represents the combined metasupport fostered by all the branches, mutually supporting each other.

We also are continuing to push ahead with plans to integrate M2M into larger, existing systems, so that M2M is more accessible to those who may benefit from its services (see Shonkoff, 2010). In this context, integration means that M2M would be formally included on the "map" of resources in the city and country, so that all women who could benefit from more support and are willing to hear about the project would be automatically referred to it before or after the birth of their children. From there, coordinators would call the mother and offer explanations and schedule an intake, if the mother is interested. In fact, we dream of making our intakes the gateway for many possible interventions for families, as in large-scale programs being implemented in the United States as part of the national effort to strengthen families (e.g., Maternal, Infant, and Early Childhood Home Visiting (MIECHV; *mchb.hrsa.gov/programs/home visiting*). In this way, Jerusalem-based professionals who are working with children and families could operate collaboratively. This, in turn, would facilitate referrals, enhance the effectiveness of individual outreach efforts, and ensure that families get what they need when they need it.

On our dream list is the founding of playgroups for fathers (e.g., see Guterman, 2012) that would offer dads company, support, and a safe place outside their homes to "hang out" with their infants. This project has not been funded yet, and we are still looking for a father who is willing to come on board as a group leader. Though one solution to the budgetary problem would be to integrate fathers into the already established (women-only) play groups, women in the groups have objected to the inclusion of men, because they say that they would not be comfortable talking about intimate topics in front of men they do not know; among some religious women, it is also forbidden. Furthermore, nursing would become impossible for many women in an integrated group. For these reasons, we need to either establish men-only groups or even better (in our opinion), find some way for mothers in our play groups to perceive fathers who want to join the groups as parents first, and men second.

Finally, we dream of bringing M2M to communities in which there is a large proportion of Arab Israelis and to Arab communities beyond the Green line (the demarcation lines that effectively divide Israel proper from areas disputed with Arab neighbors). This expansion would require considerable thought in regard to logistics, content, and security. However, with funding, we would be willing to try despite the challenges, because we would love to see M2M as a vehicle of peace, "driven" by a cohort of mothers caring for other mothers, who need their help.

Summary

We offer the services of M2M to mothers of young infants who need more support than they have available to them. The aim of the project is to strengthen mothers and their families by pairing them with a volunteer home visitor for up to a year after childbirth. According to attachment theory, the "hug" afforded by such a partnership, bound in trust and understanding, empowers, validates, and provides an excellent venue for mindfully sorting out the complexities that may arise after a new baby is born into the family. Evidence from data collected from participants

thus far attests to mothers' gains in the project and their satisfaction with it. Challenges, plans, and dreams abound, including expansion of the project to the antenatal period and to dads. In the future, we hope to see M2M used as a hub for referrals and for training and supervision of professionals working with families. In this way, M2M could work most effectively toward the best interests of society, which should prioritize the health and well-being of mothers, fathers, infants, and families (see Harris et al., 2007).

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Staff members (coordinators) of the M2M program are crucial to its ongoing success. Miriam Chriki, a founder of M2M, is a developmental psychologist. Naomi Tessler, a social worker and breast-feeding counselor, joined M2M as a home visitor in 2001 and was hired as a coordinator in 2003. In 2009, Naomi founded and continues to facilitate the weekly M2M play group, located in a community with many young, low SES families. Our newest coordinator, Judith Levy, came to M2M as a volunteer to earn credit toward her BA degree at Hebrew University, then was hired as a staff member in 2014. In addition to working as a project coordinator, Judith is working toward her MA in Early Child Development at Hebrew University. The coordinators are salaried; Marsha Kaitz is not. The four of us make up the Jerusalem-based branch of M2M and wake up each morning with a firm sense of love for the work.

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