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Staying Connected While Nurturing an Infant: A Challenge of New Motherhood*

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Abstract: Fifteen at-risk new mothers participating in a volunteer home-visiting program were interviewed about their experiences with these home-visitors and their relationships with close family and friends after their babies were born. Results of the qualitative analysis, viewed through the lens of Relational Cultural Theory (RCT), detail the social isolation and personal disconnection that they experienced. Their narratives also provide insights about the volunteers' use of techniques—such as validation, affirmation, consistency, and emotional and instrumental aid—to enhance the mothers' self-confidence in caring for their babies, to reduce painful feelings, and to increase interpersonal connections. Recommendations are included for working with couples anticipating a new baby.

Key Words: home-visiting, infancy, motherhood, postpartum depression.

The postpartum period is charged with mixed emotions for most mothers (Blumfield, 1992; Epperson, 2002). Feelings can range from pleasure and joy to anger, loneliness, and depression. In addition, mothers of newborns in many Western cultures report feeling isolated from other adults (Cowan & Cowan, 2000; Graham, Lobel, & Stein Deluca, 2002; Nicolson, 1998). They are at increased risk of mood disorders such as depression and anxiety. Thus, their infants are vulnerable to early developmental deficits because of compromised parenting (Lyons-Ruth, Connell, Grunebaum, & Botein, 1990; Weinberg & Tronick, 1998). However, few studies have closely examined the different ways in which postpartum women feel isolated and lonely.

Not surprisingly, reports show that mothers of newborns benefit from emotional support. (Gomby, Culross, & Behrman, 1999; Heinicke et al., 1999). Home-visiting interventions have been used as a means of support, education, and prevention to address the needs of women and infants during the postpartum period (Gomby et al.; Heinicke et al., 1999; Taggart, Short, & Barclay, 2000), but studies are needed that detail the usefulness of the home-visitor/new mother relationship from the client's perspective. We examined at-risk postpartum women to understand their relational experiences with their babies and families, and the social context within which their new mothering experiences occurred. We also sought information about

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their perceptions of their relational experiences with their home-visiting volunteers.

Postpartum Experiences and Relational-Cultural Theory

Postpartum ''blues'' are estimated to occur in 26%–85% of women from all socioeconomic levels in the United States (O'Hara, 1994). Symptoms can include mild to moderate sadness, tearfulness, emotional ups and downs, anxiety, and sleep problems. These feelings can contribute to women's sense of isolation or disconnection. In addition, it is possible that being isolated can add to the feelings that encompass the ''blues.'' New mothers may feel particularly lonely in their new roles because of the difficulty of sharing these unpleasant feelings. They also may be fearful of and unable to care consistently for their new baby and or lack the support of an adult experienced in parenting newborns who can offer guidance and affirmation on the challenging aspects of parenting an infant.

Relational-Cultural Theory (RCT; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) offered one perspective on mothers' postpartum moods, positing that women develop and function optimally in relation to others. Understanding, being understood, experiencing empathy from and toward another, and feeling interpersonal connection are all central values in the development of women's sense of self and the skills and values that women bring to relationships of all kinds (Jordan et al., 1991; Miller & Stiver, 1998). In fact, a loss of connection with important relationships can cause feelings of sadness, anger, loneliness, and depression, and feelings of being misunderstood. Subsequently, a woman might experience her needs, feelings, and thoughts as separate from and incomprehensible to other valued people (Kaplan, 1991; Miller & Stiver). It is possible that many women who nurture a newborn experience disconnection from their primary forms of support (usually their partner and or other family members) because of the intensity of the birth and perinatal experience, and the different rates by which women and men reportedly transition to the role of parent (Cowan et al., 1985). These disconnections during the postpartum period can contribute to women's reports of postpartum anger, sadness, and depression (Blumfield, 1992; Graham et al., 2002; Nicolson, 1998).

Home-Visiting Interventions

Home-visiting interventions are used to provide direct services to new mothers, infants, and families during the challenging postpartum period (Gomby et al., 1999). Such interventions are seen as effective in part because they bring the service to the client, and they allow the workers to observe the environment in which the mother and infant reside (Gomby et al.; Olds et al., 1999). By meeting the client in her home, the home-visitor is better able to assess the family's needs, strengths, and challenges and develop the intervention that is best suited. In addition, she is able to build a trusting relationship that can serve as a bridge to enable an isolated mother to branch out into the community for ongoing support.

Many home-visiting interventions are performed by trained professionals—nurses, social workers, or counselors. In previous studies, home-visiting interventions were evaluated on numerous outcomes, including effectiveness in enhancing parent knowledge, attitudes and behavior regarding childrearing, prevention of child abuse and neglect, and enhancement of the life course for the mother, among others (Gomby et al., 1999; Olds et al., 1999). Most of these interventions use curricula that educate the mothers on nutrition, child development, and parenting skills, and provide referrals to local support services. The relationship with the home-visitor is mentioned in this literature only as it relates to the implementation of these services (Gomby et al.).

Other researchers and clinicians assert that the quality of the relationship between the home-visitor and the mother is an important

predictor of treatment outcome (Heinicke et al., 1999; Lieberman & Pawl, 1993; Slade, 2002). The home-visitor's foci in the intervention are on emotional and social aspects of the parent, parent-child relationship, and or child functioning. Through the care and attention paid to the relationship, the home-visitor reinforces the mother's ability to keep her own needs in mind, and also enables the mother to be open and responsive to the multiple needs and experiences of her baby (Slade). These relationship-based interventions are characterized by a sustained connection between the mother and home-visitor that lasts anywhere from 3 months to 3 years, and involves regular visits throughout the service period (Heinicke & Ponce, 1999; Mayes, 2002).

Volunteer Home-Visitors

Although most home-visiting programs employ professionals, paraprofessionals and volunteers also are involved in this type of intervention. Whereas the professionally trained worker is able to fulfill many valuable functions, the paraprofessional or lay worker adds elements that the professional may be less able to provide, such as role modeling, increased client empathy from having been a new mother herself, and shared experience from living in the local community (Hiatt, Sampson, & Baird, 1997).

Researchers in Australia examined the impact of volunteers in a home-visiting project for multistressed new mothers (Taggart et al., 2000). They concluded that through friendship and the commonalities of motherhood, the home-visiting relationship did address the feelings of loneliness and isolation that the new mothers reported. In addition, the mothers experienced the volunteers as equals, and therefore felt no fear of harmful consequences if they shared with the volunteers their difficulties in coping.

Connection as Intervention

Numerous studies confirm that the postpartum period is a time of great adjustment and one in which the mother benefits from support (Cowan & Cowan, 2000; Feinberg, 2002; Pancer, Pratt, Hunsberger, & Gallant, 2000; Paris & Helson, 2002). It is a time ripe for intervention. Even before the birth of a child, women often anticipate personal needs for increased support in the face of parenting a newborn. A study of low-risk pregnant women found that when a woman anticipated support from her husband after her baby was born, she was more likely to be depressed if such support was not forthcoming (Logsdon, McBride, & Birkimer, 1994).

RCT provides an approach to working with various types of clients that includes a range of therapeutic interventions. A central construct in the theory is ''relational empowerment'' (Surrey, 1991), a process of emotionally connecting with another person through the ''capacity to be responsive and 'moved' by the thoughts, perceptions, and feeling states of the other person'' (p. 167). Being ''heard'' empowers clients to feel ''… enlarged, able to 'see' more clearly, and energized to move into action'' (p. 167–168). Applied to the intervention we studied, by showing empathy for the new mother through engagement and understanding, the home-visitor would enable her to feel empowered in the parenting role.

The Study

In the study reported here, 15 women who were participants in a home-visiting intervention for new mothers at-risk because of depression, isolation, and/or lack of resources were asked to describe their relational experiences with their baby and family members during the postpartum period. These primarily first-time mothers also were asked to describe the relationship that developed with their home-visitor and its impact on their lives. We were interested in how they characterized the various feelings they experienced (e.g., loneliness, isolation, insecurity, resentment) during the postpartum year, and whether they perceived that the support of a home-visitor assisted them with those feelings.

Responses were analyzed using the lens of RCT (Jordan et al., 1991; Miller & Stiver, 1997) and employed thematic coding techniques for analysis of interview responses. This close examination using qualitative methods to understand the voices of these new mothers offers a rich and effective way to identify the most salient aspects of their experiences, and to explain how they viewed home-visitors aiding them in a time of crisis and change.

Method

The first author, an academic researcher, provided consultation to the staff of a community-based nonprofit agency for the design of the study. Located in a large metropolitan area, this agency offers a range of services, including mental health, geriatrics, adoption, and counseling for children and families. Over the past 10 years, the agency has developed a number of programs for families with newborns and infants, including home-visiting, support groups, and individual counseling. At the time of the research consultation, the staff was interested in understanding more about their home-visiting intervention and evaluating its effectiveness.

In their intervention called ''Visiting Moms,'' community volunteers who were experienced mothers were trained by the agency in active listening techniques, problem-solving strategies, the postpartum experience, and stress in new families. They provided free weekly supportive visits over a period of up to 1 year for new mothers deemed at-risk by social service or medical providers because of social isolation, a history of depression or anxiety, or lack of resources. The relationship-based intervention offered concrete assistance (e.g., holding a baby while a mother takes a shower), educational information (e.g., parameters of a normal infant's growth and development), and emotional support (e.g., listening to a mother's fears and doubts about her ability to care for her baby in the best way possible). Given the limited amount of systematic data that the agency had collected on this program and the nature of the insights that the staff sought on the mothers' lives, we suggested that the agency employ a qualitative methodology using in-depth interviews to understand more thoroughly the participants' experiences as new mothers and their perceptions of the impact of the home-visitor relationship.

Sample

Purposive sampling was used to recruit a group of 15 women from a variety of backgrounds who were clients in this home-visiting intervention. Recruited women represented the range of program participants (e.g., partnered and single; urban and suburban; middle class, working class, and poor). Additionally, recruited women were those thought to have had diverse experiences (positive, neutral, and negative) with the services.

Participating women had received 6–8 months of the year-long weekly intervention, approximately 26–35 home-visits per woman. The majority of the mothers were in their mid-30s and early 40s, with a mean age of 38 years ($SD = 4.7$). Most were Caucasian from the United States, with two recent immigrants from Africa and Western Europe. Eleven out of the 15 were married, and 53% were of moderate income (yearly earnings between $30,000 and $60,000, blue- and white-collar jobs) by the agency's internal assessment scale. One respondent was living below the poverty line. All but two had graduated from high school, with 56% having had some college. Most women were first-time mothers, but two had older children living at home or elsewhere. Two of the women had given birth to twins. All women were referred to the program because of one or more of the following circumstances: history of depression, current anxiety, few or no supports from family or friends, lack of knowledge about mothering, tension in the marital relationship, status as a single parent, and/or having a premature baby.

Respondents were all willing to share their postpartum experiences and their thoughts about their home-visiting volunteer.

Data Collection

An agency worker contacted the respondents and secured their agreement to participate in one interview about their experiences with their home-visitor. The interviewer was a staff member of the agency who had no previous contact with the study respondents. Specific areas of inquiry in the semistructured interview with the mother included expectations of the home-visiting process (e.g., "What were you expecting from having a Visiting Mom?"); description of the home-visitor relationship and services offered (e.g., "How is your relationship with your Visiting Mom different from your relationship with other people?" and "What kinds of things do you do with your Visiting Mom?"); description of the mother's postpartum period (e.g., "What was happening for you after the baby was born and you decided to get a Visiting Mom?"); and description of her relationships with family and friends (e.g., "Were there changes in your relationship with your husband/partner after the baby was born?").

Respondents were informed by the interviewer that the information provided would remain confidential. The interviews took place in the respondents' homes to maximize convenience and allow them ease in caring for their babies. Interviews lasted approximately 1 hour, and were audiotaped and later transcribed verbatim.

Analysis

Our analysis followed the guidelines recommended by Leiblich, Tuval-Mashiach, and Zilber (1998) for analyzing qualitative interview data using a categorical-content approach. In this method, coders focus most closely on the sections of the interviews that best addressed the questions at hand. These sections detailed the relational experiences of the mothers postpartum, and the subsequent interventions with their home-visitors. Using this method, other parts of the interview were used to validate or contextualize the findings where appropriate.

Initially, both authors each read four interviews from the lens of RCT to identify content categories. To preserve the emotional quality of the interviews, we used low inference descriptors that employ the participants' own words to define the content areas (Kirk & Miller, 1986). If text was assigned the same code in three or more interviews, it was considered significant. Transcripts were analyzed using multiple codes, so individual respondents could have described all of the experiences noted in the results (e.g., one mother could have had the experiences of isolation, loneliness, and disconnection). We then conferred and considered alternative possibilities until we believed that we had a clear idea of how to develop initial coding categories. Subsequently, the second author read the remaining interviews and continued to code using the decided upon schema. We conferred every four interviews to ensure that the schema remained relevant and accurate given our research questions. Where necessary, we changed and condensed coding categories. This process of line-by-line coding (Charmaz, 2002) generated several larger thematic categories. The software program ATLAS.ti (Version 4.2) was used for data management and analysis.

Results

We identified seven general themes regarding the women's relational experiences in early motherhood and their perceptions of relationships with their home-visitors. Specifically, these themes were respondents' feelings of (a) isolation, (b) loneliness, and (c) disconnection from other adults around them in the postpartum period, as well as experiences with home-visitors that were described as (d) providing a constant presence in a time of change, (e) offering validation of feelings, (f) affirming of their competence as mothers, and (g) allowing them to feel connected and taken care of.

Relational Experiences of New Mothers

In the context of describing relationships with their babies, families, and friends, the new mothers all spoke of the isolation and loneliness that

often led to disconnection. Regardless of whether a woman was responding to a question about her life situation at the time of the referral, her experiences with her home-visitor, or her thoughts regarding the program, she described in detail the changes that ensued after the birth of her baby and how those changes contributed to her varied feelings about motherhood.

Isolation. All study participants experienced some feelings of isolation or separateness. They had given birth during the winter months in a metropolitan area of the northeastern United States. For some, the isolation came from feeling homebound. Dressing an infant and navigating the cold and ice were daunting enough to keep the women from venturing outside for support and interactions with others. One woman described her experiences of isolation in this way: ''I didn't leave my bed for two weeks, and didn't leave the house for a month, and I was going out of my mind.''

Some felt isolated because they were immigrants who had come to this country when they were pregnant and had subsequently given birth; their family, social network, and familiar culture were often an ocean away. Three women spoke pointedly to this experience of isolation from family and loved ones. The first said, ''I was expecting my baby, and I was kind of depressed and lonely 'cause I had no relative around me.'' The second said, ''Because you really are in America all by yourself.'' The third said, ''When you came here, you don't have a family; you don't have a family to help you.''

Those women who were not immigrants also felt isolated because they experienced their families as unavailable. This lack of availability was sometimes due to geographic separations, life circumstances, or emotional distance. One woman described the reality for many new mothers: ''When I came from the hospital my sister was working and all my friends were busy. I was all alone. I was here (at home), stranded.''

Loneliness. For the majority of respondents (73%), becoming more aware of their isolation inevitably led to a feeling of loneliness or desolation. In addition to the isolation described above, they spoke of other circumstances that led to their feeling lonely. Chief among them were the physical and emotional demands of nurturing an infant 24 hours a day, 7 days a week. One woman described the trapped feeling of pain and loneliness in a physical way, saying, ''Sometimes I'm ready to tear my hair out … At the beginning, I was just sitting here breast feeding and staring at the walls, and just so terribly uncomfortable in my entire body, I was just … really unhappy … ''

Another type of loneliness was attributed to not having their own mothers around. The majority of the women (80%) had mothers who were far away, not available emotionally, or deceased. They wished for a senior mother who would provide them with guidance, assistance, companionship, empathy, and a mutual understanding of their new experiences. Three respondents spoke specifically of their mothers' unavailability—1 mother was deceased and 2 mothers were ill. The first said, ''We've only been up here about three and a half years or something … and my mom was living in Washington, and she was relatively young and died, just suddenly, right after … [the birth].'' The second respondent said, ''My mother is … sick, in a nursing home, so it's not like she can … you know, she doesn't even know who I am, she has Alzheimer's, so … there wasn't anybody.'' The third respondent reported, ''My mother has an illness, so she's not really able to be here that often. I was a little bit nervous as to how I was gonna be able to handle the first baby.''

The third form of loneliness came from the frustrated attempts to share the new mother experience with others who would understand. One respondent described her situation in trying to connect with friends: ''My friends have been kind of … real busy. There's one friend I have … she's never really had any experience with babies.'' For those women who were married, frustration was directed toward their spouse as well. They felt that no matter how supportive their husbands tried to be, none could understand the physical and emotional changes they experienced. In these quotes, two

women shared their thoughts about the limitations of their husbands' helpfulness and adjustment to parenting: "My husband sometimes is the stressful part" and "In the beginning, he didn't exactly get it. He didn't even know what it was about … so I went through it for two months and he would, he would think it was just me being a wreck."

An additional element to the women's experience was the fact that most were unprepared for the intense feeling of loneliness and the inability to share it with anyone who would understand. They were surprised at how alone they felt in mothering an infant. All respondents planned for the birth of their babies. A strategy for financial support during the postpartum period often was developed such that they relied on a husband's income or support from governmental assistance or savings, or they developed other plans that necessitated returning to work within a few months postpartum. All strategies required much emotional, economic, and logistical maneuvering. Given the difficulty of securing support for this period, that one woman was contemplating modifying her plan is noteworthy and perhaps indicative of the magnitude and challenge of these unexpected feelings of loneliness. She said, "I find it very lonely! I find it quite lonely. So I don't know … I thought I would be a stay-at-home mom for at least 2 years. I might have to tweak that."

Disconnection. The feeling of disconnection or detachment from other adults around them was a prevalent response to new parenting. For some new mothers ($n = 9$), this was sharply felt in relation to those from whom they once found support and understanding, such as husbands. This disconnection might have been due to the change in schedules that the couples had made to provide care for their infants. Comments such as "We never see each other now" were common. For others, the disconnection came from feeling emotionally distant because each filled dissimilar roles in caring for the newborn; for example, the husband served as financial provider and the wife served as daily caregiver. These changes were particularly notable for our respondents in their mid-30s to early 40s, who had been working for many years. Two new mothers described these challenges.

> We have less time for each other, you know. He goes to work and it's been financially difficult for us, losing my paycheck. His schedule is so crazy. He's mostly at work. So you know, it's usually me and the kids.

Respondents evidenced an element of surprise at how disconnected they felt from friends, family, and partners. Some even felt disconnected when they were in support groups for new mothers. They reported that they could not relate to the discussions of the other women who might have been younger or had more abundant resources available to them. One woman related her experience in this way:

> The first mom's group I went to was horrible. I went to one, and I didn't have anything in common with any of the moms and they … all have more money than we do, they all own their own homes, none of their husbands work seven days a week … people were looking at me like, "You don't have a nanny?" or you know, "The baby doesn't have his own room?" I mean, I felt like … not only do I have a baby who screams all the time, but he doesn't have his own nursery … I was a wreck.

Relationships with Home-Visitors

The relationships with home-visitors were overwhelmingly positive for these new mothers, yet few understood what they were signing up for when they were referred by a social worker, nurse, or friend. One woman stated, "I didn't really KNOW what to expect, actually. I just kind of jumped in … I just thought it was a GREAT concept, the little that I knew" [emphasis in original]. Other women clearly described having hopes and expectations, but they did not know whether those hopes and expectations would be realized. A respondent shared, "I prayed to God to give me a nice

person to have [as] a friend, you know.'' Another said, ''I was looking … anything to make me feel less isolated and less lonely in this new task.'' A third reflected, ''I think it's advice, I felt so incompetent at the time as a parent, somebody who could give advice as necessary.'' One woman emphasized the special difficulties of being a foreigner in a strange culture without the support of family and the subsequent helpfulness of a home-visitor. She said, ''It's very useful, especially for a foreigner, when you came here you don't have a family … you don't have a family to help you.''

We heard the importance of the home-visitors' support and empathic stance in the respondents' descriptions of the intervention. The connection with the home-visitor was extremely important to all of the new mothers and formed the basis for the intervention's value. Respondents described different helpful aspects of the relationship. Some were more articulate in their descriptions of what specifically was beneficial to them. We coded these transcript excerpts in the following ways: the Visiting Mom's (a) being a constant presence, (b) providing validation, (c) offering affirmation of the mother's competence, and (d) allowing feelings of connectedness and being taken care of. All study respondents described some of these positive benefits from this home-visiting intervention.

Constant presence in a time of change. Many of the mothers ($n = 9$) felt isolated and overwhelmed caring for their infants and would not have been able to make weekly appointments outside the home. They discussed the importance of their home-visitor initiating the weekly appointment. The home-visitor called the mother, asked when the best time was for a visit, and appeared consistently every week. That the home-visitor began the process and reliably followed through weekly enabled the women to feel connected with someone who was thinking about them and ultimately left them feeling less isolated. Three respondents described their experiences: ''It was useful just to have somebody there, someone coming in … or to know I wasn't gonna be alone with him''; ''She's just kind of been a constant outside person while there've been all these changes going on''; and ''I think it's been … something really useful … having sort of a continuity of having … her coming by every week, or almost every week … over a period of time.''

Providing validation. We found that the home-visitor used her listening skills to develop a nonjudgmental and supportive relationship. A number of women ($n = 10$) expressed relief in not being told how to parent. In some situations, this feeling of validation or affirmation stemmed from the home-visitor demonstrating an acceptance of the mother's mixed emotions. One woman described how she felt comfortable and affirmed in sharing both negative and positive aspects of her mothering: ''…just even making me feel that things are normal…that other moms go through similar things, and she went through similar things…'' Another woman described the particular way she felt helped by her Visiting Mom saying, ''It's more just an affirmation of 'its all right that you're feeling this way right now' which has been very helpful.'' Similarly, a third woman described feeling validated by being able to share her authentic mixed feelings, something she was unable to do with anyone else.

> I just wanted there to be somebody else that I could talk to about what was going on. I mean, 'cause most people are just so … upbeat. ''Oh, you've got a baby! That's so WONDERFUL. Isn't it so GREAT! Don't you love your baby and everything!'' And I was just in absolute pain and not in a good space. [emphasis in original]

This woman went on to describe that she was able to share with her Visiting Mom how bad she felt about these painful feelings, and how this process eased her feelings of isolation.

Offering affirmation of mother's competence. We saw that the home-visitors' affirmation of the new mothers was highly valued by the mothers, because the home-visitors themselves

had experience in mothering. The home-visitors' affirmation of the new mother's competence in the form of reflecting on her already-obtained skills in reading her baby's cues was highly valued by the mothers. By identifying and pointing out what the new mother was doing well and joining with her in the joy of her infant, the home-visitor affirmed the new mother's competence in the tasks of caring for her child. One new mother reflected on her home-visitor and said,

> She's let me know I'm doin' a good job. And I think sometimes I'm doing a good job, and sometimes … I don't know. I mean, the baby gets the attention and the love, and he's sucha good kid. He's happy, so, if he's happy I know I'm doin' somethin' right. You know? But … I don't know … she says that I'm doing good. And she seems to understand things I go through.

Another mother shared similar feelings: ''She has been generally supportive in statements like 'I'm a great mom … I'm doing the best I can' and she (baby) seems healthy so she's given ME positive comments that I really don't hear from other sources at this time.''

Allowing feelings of connectedness and being taken care of. The new mothers described feeling better because they had someone with whom to connect and share their troubling feelings. Their experience of being cared for by their Visiting Mom in turn enabled them to feel less alone. Three respondents described their experience in this way.

> I just felt connected and taken care of, and that was just a great resource to have. I felt like I could bring up anything about new motherhood and it wouldn't phase her. I feel a lot better knowing there are people I can talk to … whether they don't have a solution for me at least when you talk to someone that's a relief.

Another woman detailed what she experienced with her Visiting Mom, saying,

> So I really appreciate what I get out of it. I'd say…the talking, having someone listen, someone witnessing what goes on, was also important. Whether it's with him (baby) or how difficult he is or even relational stuff.

Discussion

This study describes the relational experiences of 15 at-risk new mothers who were participants in a home-visiting program. Broadly, the study queried them about their relationships with close family and friends soon after their babies were born, and their experiences with their home-visitor. Viewed through the lens of Relational Cultural Theory, the results provide an in-depth understanding of the relationship challenges and surprises that these women faced. In addition, the study describes how the participants viewed their volunteer home-visitors as important sources of connection and support. From the mothers' descriptions, we were able to tease out different types of loneliness and the diverse ways that they experienced help from their home-visitors. Given the negative impact of isolation on women and infants, that these new mothers felt connected with someone who had lived through similar life changes and understood the new mothers' experience is an important finding.

Postpartum Relational Experiences

The women in our study reflect the millions of mothers in the United States who experience some mild to moderate form of postpartum ''blues'' (Epperson, 2002). The loneliness and isolation described by these participants is far more common today than 50 years ago. Currently, large numbers of women are living far away from close family and often go through their first parenting experience on their own. Even with advances in policy, such as the Family and Medical Leave Act of 1993 (Public Law No. 103-3), husbands or partners are back at work within brief periods.

Few of the women in this study anticipated the social isolation that they later experienced. Most had partners whom they thought could be depended on for support and connection. As Logsdon et al. (1994) found, our participants' feelings of isolation and depression may be exacerbated by unmet expectations of husbands, family, or friends. Despite the increasing accumulation and dissemination of scientific knowledge to the public about postpartum mood disorders (Cox, Murray, & Chapman, 1993; Epperson, 2002), most of the women studied were surprised by their feelings. Images of motherhood as glorious and fulfilling are promulgated in the media, and thus are still the dominant expectation of women having their first child. In addition, few expectant couples anticipate the divergent psychological ways in which they may enter parenthood, and hence they do not actively anticipate the process or seek out the necessary supports (Cowan et al., 1985). Although we only focused on new mothers and not their partners, this theme emerged as a significant and painful area of insight for them.

Relational Empowerment

RCT offered a useful framework for understanding mothers' lonely and depressed feelings, particularly with regard to the isolation from husbands, family, and friends. Surrey (1991) described the difficulties when important connections cannot be sustained through a transition. ''When an important relational context cannot enlarge to allow for mutual experience and the movement of dialogue, women feel disempowered. If the connection feels severed there can be a sense of deadness … non-vitality'' (p. 172). Our participants spent their postpartum days and nights caring for their infants. Yet, like many other women who desire meaningful connections, they sought a ''mutuality of understanding'' with others around their new parenting experience, and they were often disappointed. Although they may have experienced an intense connection with their babies, that was inadequate. They needed to be able to share the experience with adults, such as husbands, partners, or other people to whom they were close. If the context of these relationships did not enlarge to allow room for the new mothering experience, the respondents felt alone and disconnected.

With their Visiting Moms, the new mothers felt validated just knowing that they could share honestly the mixed emotions they experienced. The home-visitors did not expect them to feel or behave in any particular way, which enabled the new mothers to voice real concerns about themselves, their partners, and their babies. At a time of increased isolation, the new mothers experienced the home-visits as the high point of their week. This was an important constant in their lives. For 1–2 hours the new mothers could share the feelings of being overwhelmed, ask questions that seemed ill-informed, or just have someone else hold the baby. Sharing these experiences, even for a short time, enabled many of the respondents to feel calmer, less alone, and subsequently less disconnected from others around them. They experienced a kind of ''relational empowerment'' (Surrey, 1991), where feeling ''heard'' enabled them to move into the ''action'' of caring for babies and connecting with others around them.

Volunteer Home-Visitors

Many mothers expressed feeling less isolated and more able to care for their babies with the support of their volunteer home-visitor. The results were similar to those of Hiatt et al. (1997), who pointed out that paraprofessional home-visitors are important role models for new mothers, particularly because they act as ''mentor-mothers'' and not professionals. Interestingly, these findings could be viewed as contrasting with the work of Olds et al. (1999), who question the efficacy of paraprofessional home-visitors. However, we think that our in-depth interviews and qualitative analysis methodology enable us to understand the mother's perception of the intervention, and therefore offer another view of the use of paraprofessionals in home-visiting programs.

The meaning of the volunteer status of the home-visitors and the importance placed on it by the new mothers was not thoroughly explored here. However, respondents reported that it was a significant element in the intervention, similar to findings in the Australian program (Taggart et al., 2000). Our participants appreciated that the home-visitors took their own time to help them. This may contribute to the new mothers' perceptions of the authenticity of the relationships and the feeling that the home-visitor was like a much-needed friend.

Importantly, the study is not without limitations. Participants were a small number of mostly Caucasian women in their middle to late 30s who were part of a specific agency-based intervention in one region of the country. The sample size and population limits its generalizability to any larger group of women. The depth of qualitative information affords insight into the processes at work in these types of home-visiting interventions, but it does not allow us to make any causal connections.

Implications for Clinical Practice and Program Development

This volunteer paraprofessional home-visiting intervention based on a relationship model can serve as a template for other community agencies. The usefulness of paraprofessionals has been demonstrated (Hiatt et al., 1997; Taggart et al., 2000). Our findings take the field one step further in highlighting the importance of focusing on the relationship between the at-risk mother and the home-visitor. A consistent home-based weekly intervention that serves to validate the mixed emotions that can accompany new motherhood, affirms a mother's competence in the ways that she cares for her baby, and offers support to break through a new mother's isolation is likely to prove helpful with a low-to-moderate-risk population in reducing isolation and bolstering the parent-infant relationship. Training volunteer paraprofessionals who are experienced mothers uses the popular concept of senior mentors for women who face a challenging life experience (Cowan & Cowan, 2000). In addition, given the profound types of isolation and loneliness described by study participants, any intervention aimed at improving the postpartum period and the mother-infant relationship needs to screen for and address subclinical and clinical depression.

The new mothers' feelings of isolation and loneliness also could be addressed through couples groups, such as those described by Cowan and Cowan (1995), that anticipate parenthood and educate participants about the different ways that women and men adjust to the new parenting role. Our results suggest that these sessions should discuss postpartum "blues" as one common aspect of becoming a parent, and the need to maintain communication between partners and with outside friends and family. Singles or couples should develop support plans for the weeks and even months after their baby arrives. Mental health practitioners connected with labor and delivery clinics could routinely discuss the importance of open communication in the couple's relationship and the high level of support needed during the postpartum period.

Given our findings and the fact that few studies have evaluated volunteer home-visiting programs, future research should use methods to assess objective outcomes over time, such as reduction in depression, isolation, and other risk factors and increases in parenting efficacy. Results should be tested on larger and more diverse samples, such as younger women, African-American, Latina, Asian and other ethnic or racial minority women, and immigrants and refugees who struggle with extreme disconnections in a new country. Often, these are the target populations for current home-visiting interventions. In addition, future studies should use a broader perspective to include fathers and other close family members. A family perspective is emerging in many types of home-visiting programs, but mothers still remain the primary service recipients. Studies over the past 20 years delineate the importance of fathers and partners

in children's growth and development and in composing the supportive unit for mothers and infants in the early postpartum period (Lamb, 2002; Palkovitz, 2002; Paris & Helson, 2002). Finally, although this study did not focus on the volunteers, it is important to increase our understanding of these types of home-visitors because such information is essential for determining how to best plan and supervise staff to retain them.

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