American Journal of Orthopsychiatry
2008, Vol. 78, No. 2, 141–151

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0002-9432/08/$12.00 DOI: 10.1037/0002-9432.78.2.141

"For the Dream of Being Here, One Sacrifices. . .": Voices of Immigrant Mothers in a Home Visiting Program

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Fourteen Latina immigrants participating in an innovative home visiting program for mothers of infants and young children at risk of child maltreatment were interviewed about their experiences coming to the United States, conditions they were living in after arriving, and perceptions of the intervention. Findings from the qualitative analyses detail rich, descriptive information regarding the struggles and adaptations of the immigrant mothers and families. Poverty in home countries propelled these women to move to the United States, leaving close family and sometimes children behind. Harrowing journeys to a new country are chronicled as well as the women's isolation and depression, and the strengths they utilized in adapting to new lives. Findings provide insight into the role of the bilingual/bicultural home visitors who were overwhelmingly perceived as helpful in providing emotional support, case management/advocacy, translation, education, and friendship. Implications include the need for mental health and social service providers to (a) appreciate viscerally the histories of immigrant clients, (b) understand the role of the home visitor–client relationship in enhancing client engagement and retention, and (c) recognize the multi-dimensional contribution of paraprofessional home visitors.

Keywords: immigrants, mothers, home visiting, qualitative methods

This article describes a qualitative study of Latina immigrant mothers with infants and young children at risk of child maltreatment. Interviews were conducted with the women who were participants in a home visiting program sponsored by a community health center of a metropolitan teaching hospital. The goal was to capture the women's perceptions of their immigration and resettlement experiences and the program services they were receiving. Refugee and immigrant mothers were referred for this intervention because of isolation, lack of resources, family disruption, and/or mental health difficulties.

The health center sponsoring the home visiting program is located in a diverse urban community routinely ranked as one of the poorest in the state, with over 39% of children under 18 living in families with incomes less than 100% of the poverty rate. Half of the documented residents are Latino, many speaking only Spanish. Of importance to the health center and a primary motive for the initiation of the home visiting program was the fact that the city, one of the state's smallest, had the second highest rate of child abuse statewide.

A number of research studies and clinical reports describe the experiences of immigrant women and children (Birman et al., 2005; Espin, 2006; Falicov, 1998; Hondagneu-Sotelo & Avila, 1997; Perez Foster, 2001); however, little is known about the daily lives of high-risk Latina immigrants in home visiting or other social service or mental health programs. The goals of this article are to: (1) present the experiences of Latina immigrants through their narratives about travel to the United States, life in a new country, and assistance received from a home visiting program; (2) discuss the perceived benefits provided by having immigrant mothers serve as paraprofessional home visitors; and (3) raise awareness among mental health providers about the needs of immigrant mothers.

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This research was funded by grants from the Jessie Ball duPont Fund and the Community Benefits Program, MA General Hospital. Special thanks to Blanca Alvarado, Robin Saez, Jackie Ma, and the clients and staff of the Visiting Moms Program, MGH Chelsea.

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Literature Review

Women and Immigration

Central American immigrant women have been arriving in the United States in increasing numbers since the 1980s in search of temporary employment for family support. For those without official migration documents, journeying to the United States is often traumatic and is frequently comprised of travel through the desert without adequate food or water, intimidation and assault by illegal travel brokers (*coyotes*), and fear of immigration authorities (Perez Foster, 2001). The act of migration itself can be seen as a survival strategy, given the conditions in home countries, as well as a demonstration of ability and resourcefulness (Marsiglia & Menjivar, 2004). As they arrive in the United States, most immigrants share similar challenges such as limited English speaking ability and relatively low educational attainment in home countries (Delgado, 2007). Very often they are undocumented, leaving them fearful of immigration authorities; women are particularly worried about being deported and separated from children born in the United States.

A crisis stage in the migration and adaptation process (Falicov, 1998; Sluzki, 1979) can be triggered by the birth of a child given

the isolation and disconnection immigrants experience due to limited financial and social resources. The crisis may lead to psychological difficulties, family violence, and/or child maltreatment. Migrant women, who are at a much greater risk of depressive symptoms than the general population (Vega, Kolody, Valle, & Weir, 1991), may pay a heavy price for isolation because of their family losses and traumatic experiences in travel to the United States. Progress in their adaptation process necessitates relying on traditional values and integrating resources or services from new environments (Zuniga, 2004).

Trauma and Mental Health

Many immigrants develop strength and resiliency in the face of traumatic histories and ongoing migration challenges (Walsh, 2002). Nevertheless, traumatic experiences can negatively affect physical and psychological well-being, leading to mental health problems, substance abuse, or violence (Blackwell, 2005; Perez Foster, 2001; van der Kolk, McFarlane, & Weisaeth, 1996). This is particularly true for Latina immigrants with infants and young children who are vulnerable to isolation, given that they may not be in the workforce. Depression, anxiety, or post-traumatic stress symptoms may limit a mother's ability to soothe a child's fears when she is flooded by her own pain and sadness. Additionally, the child may witness the mother as unable to function in their new environment. These relational challenges can lead to attachment difficulties (Lieberman, 2004a; Moro, 2003).

Children Left in Home Countries

Many Latina immigrants who leave children in home countries engage in planning strategies for reunification, but often mothers and children remain separated for more than 10 years. During the separation, these "transnational mothers" (Hondagneu-Sotelo & Avila, 1997) take solace in the fact that they are supporting their children and offering them opportunities that would be impossible were they not sending money home. They are hopeful that children will perceive the separation in a similar light. Although there is a long history of "comadres" (comothers) in many Latino cultures, with relatives and close friends providing care for children (Hondagneu-Sotelo & Avila, 1997; Suarez-Orozco, Todorova, & Louie, 2002), the immigrants still worry that their children may be neglected, abused, or get into trouble as adolescents. Not surprisingly, Latinas separated from their children in the migration process are more likely to experience depression than immigrant women who have their children with them or who do not have children at all.

Home Visiting Programs for Mothers and Infants

The postpartum period for many mothers in the United States is experienced as isolating and is a time when women are at risk of developing mood disorders such as depression and anxiety (Cowan & Cowan, 2000; Graham, Lobel, & Stein Deluca, 2002; O'Hara & Swain, 1996). Latina immigrants, who are separated from their families and communities of origin and are often impoverished, are at even greater risk of such emotional difficulties during the postpartum period. Concomitant difficulties in parenting and subsequent risk to their infants' growth and development can be the outcomes of this difficult time (Weinberg & Tronick, 1998).

Home visiting interventions for high-risk or vulnerable families with young children have been found to be effective for a variety of problems including isolation, depression, parenting knowledge, child maltreatment, and child development (Gomby, 2007; Gomby, Culross, & Behrman, 1999). These programs vary according to foci (e.g., emotional support, parenting education, early literacy, case management, and advocacy) and type of home visitor (e.g., nurse, social worker, paraprofessional), but the nature of the relationship between the mother as the primary caregiver, and the home visitor, is often the foundation of the program's success (Jacobs, Easterbrooks, Brady, & Mistry, 2005; Paris & Dubus, 2005; Slade, 2002). Through the trust developed in the context of the relationship, a variety of supportive services can be offered. Relational theories, such as those detailed by Stern (1995); Slade et al. (2005) and the Relational-Cultural theorists Jordan, Kaplan, Miller, Stiver, and Surrey (1991), form the foundation for many of these interventions. In essence, all of the theories referred to above discuss the need for growth through relationships. Stern specifically addresses the need that mothers have for relational support immediately after the birth of their babies. Slade details how mothers, with the assistance of a skilled home visitor, can learn to understand their infants' emotional states (maternal reflective functioning) and better anticipate their needs. Relational-Cultural Theory (RCT) addresses women's emotional growth in the context of authentic connection to others. Assistance from a compassionate home visitor who uses empathy and mutuality to understand the challenges faced by an immigrant new mother with few family, social, or cultural supports could potentially alleviate many problems such as isolation, depression, and access to resources.

Paraprofessional home visitors have been found to offer useful assistance given their social proximity to program participants. They may serve as role models or as friends, and have the capacity to empathize with a participant's experience given that they may live in the same or similar community (Hiatt, Sampson, & Baird, 1997; Taggart, Short & Barclay, 2000). For immigrants who are new mothers, another more experienced immigrant mother who speaks her language can serve as a "cultural broker" by assisting her to learn about the resources in a new country and to understand her child's development while offering emotional support that can help her feel confident in her parenting role (McGuigan, Katzev, & Pratt, 2003b).

Visiting Moms: A Unique Home Visiting Program

Home-based interventions aimed at reducing child maltreatment face challenges in working with non-English-speaking immigrants or refugees. Many of these immigrant/refugee families struggle with the impact of traumatic histories and are mistrustful of outsiders. Respondents for this study were participants in a culturally sensitive program based in a community health center called "Visiting Moms" (Paris & Bronson, 2006). The intervention uses multilingual and bicultural paraprofessionals, who are immigrants and mothers themselves, to serve as home visitors to newly arrived mothers and children. Participants are referred by health center medical providers or social workers due to risk factors such as: emotional fragility stemming from the trauma of immigration, raising infants in a new country without familiar supports and

resources, managing challenging relationships with partners, or having children with medical problems. Services can be provided for up to 3 years. Through use of a relationship-based model (Heinicke & Ponce, 1999; Lieberman, 2004b; Paris, Gemborys, Kaufman, & Whitehill, 2007), the home visitors are trained to employ active listening and problem solving strategies when working with the participants. Typical services include weekly home visits and frequent phone contact offering emotional and instrumental support, advocacy, parenting education, and referral to resources. Additional trainings for home visitors focus on topics such as the impact of trauma, family violence, child development, and advocacy within the medical, educational, mental health, legal, and social service systems. Weekly supervision with a licensed clinical social worker serves to mentor and teach the home visitors necessary relationship-building skills, as well as the most useful approaches in home visiting. The main premise of the program is that by providing support, education, and referral to resources for the immigrant mothers, within the context of a trusting relationship, isolation, depression, and stress levels will decrease, thereby removing some primary risk factors for child maltreatment.

Method

Study Design and Questions

This qualitative study sought to document and describe the experiences of Latina immigrant participants in a home visiting program to understand their needs and perceptions of the intervention. To fulfill this aim a bilingual/bicultural research assistant, working with a culturally sensitive nonbilingual research investigator, interviewed 14 Latina respondents. Each interview was conducted face-to-face and lasted approximately 1 hour. Mothers who served as study respondents were asked to describe their experiences in coming to the United States, the conditions they lived in after arriving, and their perceptions of the home visiting intervention. Central areas of inquiry were: (1) how mothers experienced their travel to the United States and transition to their new homes, (2) how those experiences affected their mental health and abilities to parent young children, and (3) how they perceived the relationship with and services from the home visitor and the program.

Use of qualitative methods is ideal for eliciting a "thick description" (Geertz, 1973) of the experiences of immigrant mothers so mental health and social service professionals can appreciate the profound challenges they endured in moving to the United States and parenting young children without family and community support. In addition, qualitative methods can facilitate an articulation of participants' perceptions of the home visiting program, offering service providers important information regarding program focus and client engagement and retention.

Data Collection

Using a purposive sampling strategy, staff of the home visiting program ("Visiting Moms") was asked by the outside evaluation team to generate a list of all current program participants who had received services for 8–12 months. As "Visiting Moms" is a small program, approximately 28 women were eligible to take part in the study. Of those mothers, 18 were Spanish speaking and 14 of them agreed to participate. Five other mothers from Africa and the Middle East were interviewed but, due to the vast cultural and migration differences, only findings from the Latina participants will be presented here. As Central American immigrants are understandably cautious about talking to strangers, 78% participation rate was considered acceptable.

Each program participant was given a letter by the home visitor explaining the study and asking for permission to have a researcher contact them to arrange an interview. No coercion was used. Specific areas of inquiry in the semistructured interviews included: (a) experiences in the immigration process (e.g., "Please tell me how you came to this country," and "Can you describe your experiences during the first years in the United States?"); (b) impact of living in a new country on participants' concrete and emotional needs (e.g., "When you first came here, what type of help did you need? and "In what ways do you think living in the United States has affected your mental health?"); (c) difficulties that led to the program referral (e.g., "What difficulties were you having when you were referred to the Visiting Moms Program?"); and (d) experiences with their home visitor (e.g., "What kinds of help or services do you receive from your home visitor?" and "What is important to you about your home visitor and the services she provides?"). Often, responses were probed for greater depth and additional opinions (e.g., negative aspects of the program).

The interviews took place in the respondents' homes to maximize convenience and allow them ease in caring for babies. The research assistant read the informed consent materials to the participants in Spanish as literacy was problematic for many of the women; all interviews were conducted in Spanish as well. The fact that the researchers were not part of the health center was explained in order to underline confidentiality and maximize the possibility that information could be shared without worry that the home visitor would find out. Respondents were offered a $15 gift coupon to a local market for their participation. Twelve out of 14 interviews were audio-taped and transcribed verbatim into English by the interviewer. Two of the respondents refused audio-taping. For those interviews the researcher took extensive notes during the session and filled in any details after concluding the interview. Translations were checked by another native Spanish speaker. The researcher verified transcriptions for accuracy by listening to each recording in full and making any necessary corrections. In addition, she wrote summaries of each interview after it was transcribed.

Sample

Respondents ranged from 25 to 38 years old with an average age of 31. They were monolingual in Spanish, from Central America (11 from El Salvador, 2 from Honduras, and 1 from Guatemala) and had been in the United States on average for 5 years. Three of them had no formal education, 6 had attended some elementary school, 3 had attended high school, and 1 had attended some college, all in their home countries. Half ($n = 7$) of the respondents were functionally illiterate in any language. Approximately one third were married or partnered ($n = 5$), another third were single ($n = 5$), and the remainder were separated or divorced ($n = 4$). Most came to the United States by land ($n = 13$) assisted by a travel broker or *coyote* who accompanied them from home countries or met them in Mexico. Four women had attempted the trip once before, but were caught and sent back. On average the cost of

the trip was $6,000, money that was typically borrowed from family or friends. Thirteen out of the 14 respondents were undocumented when they arrived in the United States. The women were all met by relatives or acquaintances when they arrived at their destination city. Degree of closeness to the people who "received" them varied, but most respondents reported having some place to sleep even if it was on the floor of someone's room. At the time that they were receiving services, 12 of the women and their children were living in overcrowded apartments with roommates, strangers, or nonfamily members. None of the respondents were employed when they were referred to the program, although most had worked soon after arriving in the United States. Approximately half of the women ($n = 6$) left children with relatives in their home countries; the remainder ($n = 8$) became mothers for the first time in the United States. On average the respondents had three children each (range = 1–6), but the average number of children with them in the United States was approximately one and a half (range = 1–3).

Analysis

In this study, both inductive and deductive approaches to data coding were used. The immigration literature provided us with initial ideas regarding migration and resettlement experiences for these Central American women. Hence, we asked about and listened carefully for the details of travel to the United States and experiences after their arrival. Because many home visiting programs prioritize the relationship between the home visitor and client as the main vehicle through which the intervention occurs, as was the case with Visiting Moms, we asked about, and were particularly mindful of, the respondents' perceptions of their home visitors and how they described not just the services, but the meaning of the relationship with the home visitor. Essentially, guided by the literature and relationally focused theories such as RCT, we anticipated that we would hear about many disconnections and isolation in the experiences of travel and resettlement and reconnections through their relationships with their mentor mothers from Visiting Moms. As with any qualitative coding process, we remained open to the unanticipated replies of the respondents.

Responses were analyzed using grounded theory techniques and sensitizing concepts (Charmaz, 2006) from theories of relationship-based interventions, to assist in the development of themes (Heinicke & Ponce, 1999; Jordanet al, 1991; Slade, 2002). The qualitative data analysis computer program Atlas.ti (2005) was used for coding and data management. Initially all interviews were read by the principal investigator. Subsequently four interviews were coded line by line in an open coding process (Strauss & Corbin, 1990) by two graduate student research assistants in consultation with the principal investigator, allowing for a close examination of the transcripts. We then conferred and considered alternative possibilities until we believed that we had a clear idea of how to develop initial coding categories. Following this process, the two graduate student research assistants coded the remaining 10 interviews, consulting with the principal investigator every three interviews. Each coder constructed thematic summaries describing the range of experiences of the respondents with regard to the research questions; these included how respondents came to the United States, their difficult travel experiences, adaptation to life in a new country, fragmentation of families, raising infants and young children, leaving children in home countries, and types of help received from the home visitors. The interview codes were then organized into larger themes or categories for further analysis. These themes were then analyzed further using clustered matrices (Miles & Huberman, 1994) which allowed for comparison across respondents.

Results

Analysis of interview data revealed rich descriptive information regarding the struggles and adaptations of the immigrant mothers and families. Three overarching themes were identified that followed the organization of our interviews: (a) beginning the immigrant journey; (b) life in a new country; and (c) the helpfulness of the home visitors in supporting adaptation and resiliency. Each theme was composed of specific categories including: (a) the immigrant journey—reasons for coming to the United States and suffering in travel to a new country; (b) life in a new country—isolation, depression/sadness, children left behind, and personal strengths and supports; and (c) helpfulness of home visitors—emotional support, case management/advocacy, translation, education, and friendship.

Beginning the Immigrant Journey

All of the respondents spoke about their experiences in their home countries, the reasons why they emigrated, and the particular struggles they faced leaving Central America, traveling through Mexico and arriving in the United States. Notable was the fact that they each had someone, family, friend, or acquaintance, to "receive" them and help them get started in their new environment. The majority had a family member already in the United States, although not necessarily in the community where they settled. None had difficulties locating a travel broker or *coyote* to assist them on their trip and one woman had even worked for this broker, receiving a discount in her costs.

Reasons for coming to United States. The majority of the respondents spoke about leaving their home countries for financial reasons ($n = 10$), although others stated that the main motivation was reuniting with their partners or family members who had already emigrated for economic opportunities ($n = 3$). Six respondents described their inability to support their children in home countries, often commenting that they could not even afford notebooks or the cost of school. A few also mentioned the need to support other family members. One woman said, "Another reason I decided to come over here, is to help my mother." They saw no viable employment options at home and all described the desperate poverty that they had experienced. In this sample of immigrant women, fractured family lives also contributed to poverty. Six of them had been abandoned in some way by their partners/husbands, one respondent feared severe interpersonal violence, one came because her husband had died, and two had husbands already in the United States. The majority of women felt they had no choice but to emigrate if they wanted to support themselves, their children, and/or other family members. Maria and Anna (pseudonyms are used throughout) described their reasons for emigrating:

> You know one comes with a goal/one thing in mind . . . to work . . . because one's country is so poor and one has to come here to do

> something because I have so many kids and my husband . . . we left each other. And I had to move on . . . forward . . . for my kids. *Maria*

> Look . . . I decided because of this. I was left a widow because my husband died of cancer . . . I came with hopes of working and having money for my kids. Because you know when someone is left alone it is not the same. Because the husband is the primary head of the household [financially]. It was not the same anymore. So, I said this is the way it has to be. *Anna*

Suffering in travel to the United States. Thirteen of the women came to the United States by land and one by plane. The trip took anywhere from 15 to 45 days from their Central American homes to the city in the United States where they would eventually settle. Painful stories were described about the process of crossing over from El Salvador, Honduras, and Guatemala. Moving within Central America and Mexico caused few problems. The majority of respondents reached the northern region of Mexico by car or bus. However, they traveled into the United States by foot, walking through the desert and crossing rivers. One respondent was five months pregnant during her travels. The motivation was strong and the dream of a better life or connection with a family member in the United States sustained them through lack of food and water, adverse weather conditions, or medical illness. As Luz stated:

> One suffers by land. It is not easy. We walked a lot. We had to withstand the cold, thunder, and without sleeping or eating. For the dream of being here, one sacrifices and suffers. I came sick along the way. When we were in Guatemala, they gave me three injections. Because I came very sick from giving birth from my other baby. I left her very young. Before leaving El Salvador, they had given me some medicine. Then when I got to Guatemala they gave me three more injections and I became worse. Without eating, sleeping, and like this. I came here so thin . . . Almost dying . . . well, on my part, if they caught us, I would not attempt the trip again.

All of the women who traveled by land described the frightening conditions that they lived through. There was the physical suffering, the heat of the desert, the lack of food and water, and the fear of assault by travel brokers or others they would meet on the road. Uniformly, there was fear of *La Migra* (immigration authorities). Four of the respondents were caught and sent back to Mexico or to their home countries. Anna described her experience avoiding the immigration authorities and Lilliana of being caught and "thrown" out of the United States:

> I landed in Los Angeles. It was bad, passing over was bad (*La pasada estaba feo*). I called the guy to come pick me up [my husband's family member] and he took the plane to pick me up in L.A. . . . he told me that we had to take a bus because it was dangerous to take a plane to [northern city in U.S.] . . . I was getting ready to get on a bus but they [immigration authorities] got there and were going to take us away. They asked me to get in line and I told them that I was, but then I ran. I ran because they were going to send me back. The Chinese woman asked me if I needed help. I said yes and this Chinese woman was so nice. She took me into the restroom. She told me I would go in another bus. She put my luggage in another bus . . . *Anna*

> And that day the INS got us and they made us return (*nos tiro de regreso*). I was able to rest. It was the beginning of the desert. They asked us where we were from and we said we were from Mexico. They took us to get fingerprinted and to take a picture of us, and from there they threw us [down on the ground]. I was not able to stand because of the blisters [on my feet]. I could not walk because that was the day I got them. Well, once we got to the house, where we were going to stay . . . they went to get me some bandages so I could put them on . . . because the next day, we went out again . . . we spent two days in the desert . . . I was barely able to walk. *Lilliana*

Although motivation was high and there were four women who were caught by the authorities on their initial attempts, four other respondents specifically stated they would not have tried to migrate again had they been stopped. Myriam spoke for this group when she stated:

> The trip was so hard . . . the walk . . . the mountains . . . I thought, "I would not even come for my grandmother" if I had to do the trip again. I would not do the trip again, not by land . . . having to walk for three days without food . . . having to find water . . . trying to find any plant or branches to suck some water out of . . . the trip was really sad.

Loss of connection with family and community in home countries was not the primary focus of the respondents' emigration narratives. Yet, Leticia foreshadowed some of the sadness that was to come, particularly for the six women who left children behind, when she stated, "What I felt was the hardest thing about the trip was what I left behind . . . that I left my daughter behind . . . It would hurt when I would remember that one step forward meant that I couldn't take steps back."

Life in a New Country

The struggles of life in the United States were discussed by all of the respondents. Most experienced the isolation and disconnection of being newcomers with limited English language skills and few resources. Some were able to find employment and make connections quickly; others stayed hidden in small crowded apartments waiting for partners or family to take them out into the urban neighborhoods they were fearful of navigating on their own.

Isolation. Nine of the respondents reported being isolated when they first arrived in the United States because they did not know many people or have anyone they could rely on. Language problems were central to this isolation. The entire group of respondents was monolingual in Spanish, with one or two understanding a few words of English. Suzy spoke for most of the women when she said, "At first, I felt really alone . . . I would stay by myself. I was in a place I did not know. I did not know where to go. I did not even understand the law and how things worked. I would always be inside . . . "

Feelings of discomfort stemmed from the dramatic differences in daily living practices between the United States and their home countries. Some respondents were fearful of making friends and did not know the ways of socializing in a new country. Miranda's words are emblematic of what many of the women experienced, "I don't know how to make friends here with the people. I spend most of the week stuck here at home. It is only on weekends, when he takes me out sometimes . . . to a store. If not, I am usually here." The ultimate expression of isolation was described by Natali when she spoke briefly about her experience giving birth, "When I went into delivery I went by myself, I came home by myself. I was alone, totally alone."

Nevertheless, most respondents had been employed for some period of time during their stay in the United States; jobs included those in markets, factories, and laundries, cleaning homes, selling

hot dogs, or other unskilled positions. Four of them had work permits. Employment offered them the chance to earn money to send home, as well as to counter the isolation that they felt as new immigrants. Once babies were born, working became more difficult unless a woman had family willing to care for her infant; even so, many of the women managed to work part-time or on weekends.

Sadness/depression. Feelings of sadness and depression were endemic to this group of mothers and reported by 10 of them in interviews. At intake for the home visiting program, seven of them scored in the clinically depressed range and two as moderately depressed on the Beck Depression Inventory II (Beck, Steer, & Brown, 1996) administered in Spanish. The reasons for depression were varied and included loneliness, missing children/family, problems with partners including interpersonal violence, having children with special medical needs, poverty, and isolation due to language limitations, among others. Maria summed up her feelings and those of many of the respondents when she stated, "You should have seen me, how depressed I felt. The only thing I would do is cry and cry . . . I felt depressed, without any will to live." Often the depression started in pregnancy and was complicated by isolation and the inability to share the experience with trusted others. Hortensia explained:

> I was depressed during my pregnancy . . . I hardly went out, but when I did, that was the hardest thing. I would rather pay to stay inside . . . [I needed] someone to listen to me. I would spend my time crying. My brother would buy me calling cards, I would call my mother every day. I tell her everything.

Natali's partner was unwilling to take responsibility for being the father of her child. She shared how this awareness precipitated her depression:

> When I found out I was pregnant, I became really depressed because I tried to call the father of the baby and this man screamed . . . "I do not know what you are going to do because I am not the father of the baby."

Children left behind. Children were left in home countries by six of the respondents. All of these women discussed the conflict of missing their offspring yet feeling that they were providing for them as "transnational mothers" by sending money for their care (Hondagneu-Sotelo & Avila, 1997). Some discussed specific difficulties, such as jealousy by children left behind of new children born in the United States or concern that the children in home countries were not being cared for properly. Suzy described the pain of leaving behind a very young child, " . . . The hardest thing was that I left my daughter so young. I was still breast feeding her when I came. On the way here, I had my breasts so full of milk, I had to get the milk out on the trip." Maria spoke of the impact of missing her children, "In thinking of my kids. I felt depressed- . . . without any will to live . . . I told them, 'I do not know what to do because my kids are so far away.'" Leticia also spoke of the ongoing conflict for her role as a mother:

> I think it was too costly because of my daughter. It hurt me a lot to have left her. How do you say it . . . I cannot get used to not having her with me. At times, I will send money to my daughter if she needs something for school . . . I feel that I am helping her, but in reality I am not giving her the love that she deserves. With all that I can give her and send her, at some point she could ask me many questions that I will not be able to answer. Because at times, over the phone, she asks me, "Why did you leave? Do you not love me anymore? She asks me many questions and at times I remain silent. I hope that one day when she is older she will understand. I know that even with everything I am giving her, I will never be able to give her the love of a mother.

Family/friend supports. Despite the depression that most of the women experienced, all mentioned family or friends that in small or large ways helped them to adapt to life in their new country. Some had uncles or cousins who found them jobs, others had a friend who shopped with them, two had parents who helped them in the United States, and others had family members in Central America who were caring for their children. All respondents arrived in their particular United States location because a friend, acquaintance, or family member was willing to receive them. Maria described the help offered by one of her brothers soon after she arrived:

> Another brother did help me a lot. Because when I needed it the most, he extended his hand to me. He provided for me, food and everything until I felt better and I was able to get my own help. Well, he helped me a lot. He still lives here. During that time, he did not have a woman (*no tenia mujer*), he did not have to spend his money. I would cook for him and he would help me by giving me some money. That's the way we got along, until I was able to help myself more.

Myriam had a large family in the United States when she arrived. She had remained close with them although they were in a different country and they assisted her in her adaptation, "they [her sisters] helped me in everything . . . they never charged me rent." Her mother-in-law also helped her, "If there is anything I need . . . with my kids . . . she takes my kids . . . I take care of her kids . . . this is the way we are." Hortensia had crucial family support after her baby was born. She explained, "They supported me. My father was the one who would cook for me. Since I had a C-section, he would bring me my medicine, water, everything to my bed. My brother would take my clothes to the laundry."

Although immediate and extended family was mentioned most often by the respondents, a few women described important friendships without which they would have been lost. Vicki told about a particularly significant friend:

> She is my best friend . . . I care about her as though she were my own family . . . she is the one we lived with . . . when I first arrived . . . I did not know her before coming to this city . . . she helped me a lot when I first came . . . she visits me all of the time . . . we are very united . . . My friend is the one who took me . . . she is the one who showed me how to take the busses and she worked so she did not have a lot of time, but she did it . . . she helped me a lot . . . she is the one who took me to the clinic . . . I learned a lot from her.

Quality and availability of family support varied, but 13 of the women felt they benefited in some way from their connections with extended family members. Only Suzy, who was in the United States with an abusive husband, had no contact with family nearby, "I have a lot of family here. But no one visits me. I also do not visit any of them. Nothing . . . because they are people who are not very happy . . . I have aunts, uncles, cousins . . . "

Perceptions of Home Visitation Services

Despite the aid received from family and friends, respondents were in need of additional assistance. For many it was due to their

emotional fragility stemming from the trauma of immigration, from raising infants in a new country without familiar supports and resources, from managing challenging relationships with partners, or from having children with medical problems. As participants in a home visiting program they could receive mentorship from immigrant bilingual/bicultural paraprofessionals. When services from the home visitors were dependable and consistent, the respondents found them extremely helpful. The home visitors served as a lifeline of connection and assisted the mothers in caring for their children as well as negotiating their new homes. Most often, the home visitors were found to be helpful because they offered emotional support, concrete assistance through advocacy and case management, translation, friendship, and education.

Emotional support. Each of the 14 respondents reported that emotional support was a central aspect of their home visitor's helpfulness. They were able to share worries about infants, troubles in marriages or partnerships, and difficulties negotiating daily life without the advantage of English, among other concerns. The home visitors would listen and reassure; sometimes they would offer advice and guidance or direct the respondents to the appropriate agency for assistance. Suzy described her positive experience with her home visitor:

> When I really felt depressed, where I did not even know what to do . . . She would tell me to think things through. She would try to get me to see things clearly. How could I make myself feel better . . . I feel that she has helped me in so many ways. Sometimes I even tell her that I will bore her. But she tells me, no, this is why we are working with you.

Myriam's child was born with a birth defect. She worried about getting him help and shared those concerns with her home visitor:

> She would ask me if I was all right, if I was sad . . . depressed . . . We talked about my son . . . she said that I should not feel sad about [his medical problems] . . . that these are things that happen . . . she would give me a lot of advice and counsel me . . . all of this helped me because I would cry a lot . . . they counseled me well.

Many of these women were alone with their fears and concerns. Often family, when available, were unable to offer nonjudgmental guidance. However, the home visitors were culturally similar, yet separate. Trained in active listening, they were able to offer the respondents the chance to process their difficulties and think through challenging decisions about returning to Central America, leaving abusive partners, or caring for their children when they needed to find a job. Maria spoke for the vast majority of respondents when she described the trust she had in her home visitor and the way her visitor had assisted her.

> I have felt real good with her. She has advised me a lot . . . Everything she tells me, I like because she has opened my mind up. I had my mind closed off. Well, I am now a different person. I feel this is due to all of the support she had given me. I feel more relaxed. I owe her a lot.

Case management and advocacy. All 14 of the respondents perceived the case management and advocacy offered by the home visitors to be as important as the emotional support. The fact that home visitors accompanied them to appointments, made phone calls with them, bought them food or clothes, referred them to necessary services or child care, and literally stood by them so they would not be alone had a profound impact on the quality of the respondents' lives. Anna was amazed by her home visitor's willingness to stay with her, "They did not want me to be alone. Not once did I go to [the city] for an appointment by myself. Even the day I delivered, she went with me, I delivered around 11:30 p.m. and she spent all day with me." Some women needed help negotiating the U.S. Citizenship and Immigration Services. Others were referred to domestic violence or mental health specialists. In this way the home visitors assisted the women to access services that were beyond the scope of their intervention. With the referral and approval of the home visitor many of the respondents utilized services they would not have otherwise trusted or considered. Myriam, like most of the women, learned to count on her home visitor to be available to help her negotiate aspects of everyday life. She explained, " . . . the best thing about her is that whenever I have called her she has received me well . . . she has never said no to me . . . I know that if I need help with translations or filling out forms she will help me." Other respondents mentioned the countless ways the home visitors offered them concrete assistance. One stated, " . . . she has helped me with food vouchers, with things for my daughter with SSI, at times she helps me fax forms that I need to send. All of these things . . . It is a big help;" another described, "If I do not know how to get somewhere by myself, she goes with me. She has never denied me. Toys for the kids, she has given toys to him."

Translation. Acting as translators or cultural brokers was part of the home visitor's case management role. They not only translated letters, documents, and forms for appointments or services, but they explained their purpose and function. Thirteen of the women articulated the importance of the translation assistance that the home visitors provided. These three examples speak to the range of needs the women had due to limited language abilities. Claudia stated, "At times I take them [forms] to her so that she can read them to me . . . because I do not understand them exactly . . . then she clarifies things for me." Leticia described another type of language assistance, "Because at times, I have had emergencies where I needed to go places but because of the language barrier, I could not do it. I have called her and told her, 'I need this. Can you accompany me?'" Finally, Vicki clarified how her home visitor assisted her as an advocate when her limited English hampered her, "Because at times if you do not speak English, you need someone who will help you. Like I told you, the way she called the school. She did help me."

Teaching and friendship. Of the many other roles the home visitors played, the two most frequently mentioned were those of teacher and friend. The respondents learned from their home visitors about their children's development and the best ways to parent them, about cultural practices in the United States, about possible services and supports, and about the many systems they would need to negotiate. Six of the women described their home visitors as teachers. But the education was not formal. It was done in homes or at the health center, in relaxed environments where the women could respond and ask questions. Natali's words speak for those women who perceived the home visitors as educators: "Yes, she tells me how to do things and if I cannot do it, she is there with me so that we can do it together." More specifically, some of the women detailed the way the home visitors taught them about mothering. Hortensia explained, "Yes, she has helped me so much with information about being a mother, she always asks me how I

do things, she informs me about different things . . . She gives me advice . . . She tells me "no, no, no, not that. She corrects me, but she educates me." In the same vein, Miranda said:

> She tells me I should teach him how to say words. She gives me advice about nutrition and food for him. She tells me to have a schedule for him to sleep, but he cannot get used to it. At times he goes to sleep around 11 p.m. She tells me not to let him sleep a lot during the day, so that he can go to sleep earlier during the night. But when he gets sleepy he gets mad until I put him to sleep. It's not like I can have him sleep when I want. It's when he wants.

Although respondents appreciated the education they received from their "mentor" home visitors, nine of the respondents stated that they additionally came to think of them as highly valued friends. Leticia distinguished the different ways she perceived her home visitor, "Yes, I feel that she has helped me. At times we have talked about work and other times we see each other as friends. She helps me, because instead of lowering my morale she makes me feel better." Vicki explained how she came to rely on her home visitor, "I always needed her (*siempre me hacia falta*) because she came to be my friend." Finally, Myriam offered the ultimate praise, "She has been such a support . . . she has gone from being a social worker/home visitor to being a friend."

Limitations of the program. Most respondents had minimal complaints about the home visiting program. The assistance they received seemed to outweigh any negative perceptions. Some women had experienced two different home visitors and although the transitions were difficult, for the most part they found the second visitor to be helpful as well. Nevertheless, when there was dissatisfaction, it centered on inconsistency or unavailability. Three women mentioned the fact that their home visitor did not come to their home as often as she promised, would not appear for a particular visit, or would only stay for a few brief minutes. This was particularly distressing for the respondents as they had come to trust and count on their home visitors. Margarita had transferred to a new worker when her first one left the program. She missed her former home visitor and did not feel consistently assisted by her new one. She explained, "My current home visitor tells me, I will go to your house, and I am waiting for her and she never comes . . . At times she calls, but not always. Maybe she forgets." Juana was frustrated with her home visitor because sometimes the worker would tell Juana that she planned to visit her, but she (the home visitor) never showed up. Occasionally, the home visitor called the respondent to let her know that she had an emergency, but other times she did not call her at all. Juana felt that her home visitor "is inconsistent and lies too much." Although the dissatisfactions were few, they are important to highlight because offering inconsistent services to a high-risk population is a waste of resources at best, or damaging for program participants at worst.

Discussion

This study describes the experiences of Central American immigrant mothers who were part of a pilot home visiting program for families at risk of child maltreatment. The article offers knowledge of these women's experiences in migration and adaptation to the United States and helps mental health and social service providers better understand the women's needs. In addition, the study examines respondents' perceptions of the services received from their paraprofessional home visitors with the goal of utilizing the results for informing practice delivered by home visitors to refugee and immigrant women.

Findings showed that most of the respondents had faced dramatic incidents of trauma in travels to the United States and were challenged in adapting to a strange new country with limited social and economic resources. Respondents survived the physical suffering and hardship of their travels through the desert, as well as the emotional suffering of living far from their children and close relatives in an unfamiliar environment. Although they had been identified by health care providers as a group of mothers who were "at risk," their stories also provided important details about the strengths and resiliency they possessed to survive poverty and oppression in home countries and make the survival choice of traveling to the United States to support themselves and family members (Fong, 2004).

These immigrant mothers eloquently shared the pain and suffering they experienced in their travel to the United States and their transitions to life in a new country. Isolation, sadness, and depression were all parts of the narratives that were shared. Additional concerns about fragmented families in Central America and the United States indicated the continuation of struggle for many of these women. The mothers who had left children in Central America shared their particular challenges of wanting to provide financial support for their children, yet feeling distraught about being separated from them and worrying about their well-being. Although this study was not initially focused on connecting trauma histories with mental health difficulties, it is reasonable to note that most of these women's lives contained traumatic experiences from traveling to the United States. Along with current poverty, isolation, challenging family relationships, and the anti-immigration sentiment of the social environment, the experience of trauma could be one contributing factor to the depressive symptoms that were described. Not all Latina immigrants cope with the level of difficulties of these respondents; these women had all qualified for a home visiting program due to their varied risk factors. Nevertheless, it is known that many immigrants do suffer from posttraumatic stress symptoms (Perez Foster, 2001) and those that are separated from their children, like many in this study, have a greater chance of experiencing depression (Miranda, Siddique, Der-Martirosian, & Belin, 2005).

In the details that the women shared about their experiences with home visitors, as anticipated, one can see the centrality of the relationship between the new immigrant mother and her "mentor" mother (Paris & Dubus, 2005; Taggart, Short & Barclay, 2000). The relationship was built through the simultaneous processes of listening with respect, offering emotional support, and providing needed services such as translation, advocacy, and education. Providing concrete services, in the absence of the willingness to listen patiently and visit the home, would not build the same strong emotional connections and subsequent receptivity to services (Lieberman, 2004b).

The lens of RCT helps us understand the immigrant mothers' need for trusted connections with these home visitors in order to sustain them through their transitions to the United States and parenting infants in unfamiliar surroundings. Within supportive and caring relationships, the mothers were able to share authentic feelings of loss, sadness, and fear. By sharing, they experienced

greater freedom from the constraints of those feelings and felt better able to attend to their children. As RCT posits, human growth happens through connection to others. Specifically, feelings of empowerment and self-worth that grew from relational connections with home visitors enabled these immigrant mothers to feel more confident in the parenting process and in their lives in the United States.

Recent research identified specific factors important for engagement and retention of mothers in home visitation services (McCurdy, Daro, & Anisfeld, 2006; McGuigan, Katsev, & Pratt, 2003a, 2003b). Relevant for this study was the finding that isolated mothers who were depressed were difficult to engage in programs. Suggestions by the researchers for increased outreach, patience, follow-through on commitments made to mothers, and meeting concrete needs through delivery of food, cribs, toys, or other items were followed in the Visiting Moms intervention leading to participation in services by this group of isolated and depressed mothers. The few respondents who mentioned the inconsistency of their home visitor were dissatisfied with the program and less open to interventions even when they were offered.

These findings are important because they show the potential for successful interventions offered by bilingual/bicultural paraprofessional home visitors, even with at-risk immigrant families. Similar to other interventions that utilize long-term immigrants to assist newcomers with social or mental health services (Khamphakdy-Brown, Jones, Nilsson, Russell, & Klevens, 2006; Zuniga, 2004), the interventions offered by these home visitors, who were Latina immigrant mothers, were perceived by program participants as beneficial. The program participants who needed the additional assistance of mental health clinicians or domestic violence specialists received the referrals from their trusted home visitor and were more likely to follow through than if they had been sent for services by their health care provider. These findings, like those in other studies (McGuigan et al., 2003b), support the usefulness of cultural matching where possible in home visitation services that utilize paraprofessionals. Certainly there are some circumstances with very high-risk families where trained professionals are needed from the outset.

Limitations

Respondents were a small number of Latina immigrants who were participants in a home visiting program for mothers of infants and young children at risk of child maltreatment. The sample size and its high-risk status limit generalizability to any larger group of immigrant women. The depth of qualitative information affords insight into the experiences of the respondents and perceptions of the processes at work in this home visiting intervention, but it does not allow us to make any causal connections.

Implications for Public Policy

Although this study describes the experiences of a small group of immigrant mothers, the policy implications are worth noting. The mothers and their children are highly vulnerable to the often punitive changes in immigration policy. Policymakers must remain aware that broad strategies affect individual lives, causing increased stress, such as when work is unavailable due to employers' fears of hiring immigrants, or causing potentially traumatic separations between caregivers and very young children, when adults are taken to deportation centers. The findings remind us how social service delivery is often a crucial lifeline for vulnerable populations and that increased funding is necessary to address both the current needs of high-risk immigrant families and to prevent serious outcomes such as child maltreatment.

Implications for Practice

The study findings suggest several important issues to be considered by mental health and social service providers, particularly for planners of home visitation programs. First and foremost, listening to the narratives of Latina immigrant clients shows us the importance of understanding migration histories and current fears or uncertainties, in order to assess the potential impact of loss and trauma on women, children, and families. Asking about and being willing to hear immigration stories that include the adaptation process is crucial to the optimal provision of services. Without this information, providers are unable to address the negative consequences for emotional health, parenting behavior, and parent–child attachment. Initially, many immigrants may be fearful of sharing true stories about their pasts or current worries. Nevertheless, active interest and receptivity on the part of the intervener is essential for a client to begin to trust. Subsequently, providing services that are specifically designed to ameliorate the impact of trauma are essential.

Second, as helpful as these home visitors appeared to be, there were limitations in how they were viewed by some respondents. Inconsistency and inability to follow through with promised services is not at all acceptable in any home visiting program. These difficulties are not limited to paraprofessionals, but they do point out the active need for ongoing training and supervision to educate home visitors about the importance of their role, the vulnerabilities of their clients, and the challenges of a job assisting women and families in great need who may not always be interested in the type of assistance offered.

Last, discussions will continue about best practices in home visitation as we learn more about the effectiveness of new models (Slade & Sadler, 2006). Along with outcome studies, providers involved with home visiting should remember to attend to the perspectives of the clients, like those in this study, who may point to the multiple aspects of an intervention (i.e., support, advocacy, and education) that they find beneficial (Krysik, LeCroy, & Ashford, 2008). Home visiting services are typically developed to ameliorate a particular problem with specific program goals, such as reducing child maltreatment or advancing child development. The best path to these goals is not always clear and occasionally workers may emphasize one aspect of an intervention over another, and parents may perceive the intervention differently from the way it was intended, yielding unexpected results (Hebbeler & Gerlach-Downie, 2002). Those results may still be perceived as helpful, if they ameliorate a problem identified by the clients. Although it was beyond the scope of this study to assess the effectiveness of this home visiting intervention, the respondents spoke clearly about their experiences with their home visitors and identified services that were most useful in helping them to feel less alone, more connected, and able to function as parents to their young children.

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Received July 10, 2007
Revision received: February 21, 2008
Accepted March 8, 2008 ■

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