

## RESEARCH ARTICLE

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### Social Support through Social Capital: A Model of a Parent Support Group for Mothers in an Urban Head Start

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This qualitative case study highlights the content and process of a parent support group delivered through a preventive mental health intervention in an urban Head Start. A social capital framework was used to analyze data from interviews with group facilitators and Latina mothers who were the core participants as well as from facilitator evaluation forms documenting weekly group process and content. Findings suggest that close relationships and an exchange of meaningful resources constituted support. A possible model for parent support groups incorporates relationships, resources, and space whose interplay is managed by a group facilitator.

As part of its commitment to prepare children for Kindergarten, Head Start is also committed to supporting families so that children have the most supportive and enriching early learning experiences possible. Indeed, the National Center on Parent, Family, and Community Engagement in Head Start presents a comprehensive framework by which Head Start programs can design and measure their efforts around engaging families and communities (Head Start Resource Center, 2011). The empirically driven framework suggests seven family engagement

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outcomes designed to strengthen families and, therefore, children's experiences<sup>1</sup>. To achieve such outcomes, many Head Start programs align their efforts with the unique characteristics of their enrolled families.

To this end of supporting families, Family Connections is a Head Start-based preventive mental health intervention designed to increase program staff's capacity to deal with families and children who might be dealing with depression and related adversities. The intervention primarily offers staff-wide training sessions and mental health consultation to teachers and staff. In the urban Head Start where an evaluation demonstrated that the program was safe, feasible, and an effective tool for system changes (Beardslee, Ayoub, Watts, Avery, & O'Carroll, 2010), the program also offered a parent support group, and this qualitative case study highlights the content and process associated with the support shared in the group.

A core group of Latina mothers attended the group, which became an opportunity for participants to negotiate critical resources for supporting their children's learning and meeting personal goals. With the help of a mental health consultant who facilitated the group, the mothers engaged around issues that felt most pressing to them in a given week. These included parenting, economic challenges, social isolation related to their immigrant or ethnic minority status in their communities, and working towards personal goals.

This study presents both the content of the group and its process for the sake of a rich understanding of how its members benefitted from it and to suggest a possible model for future groups in Head Start or other early education contexts. While experimental or evaluation studies are the best for quantitatively measuring effects, a qualitative case study such as this presents nuanced content and process of the group through its participants' voices in a way that can't be captured with large-scale or quantitative data.

Two main questions guided this study:

1. What constitutes support from the perspectives of key players in a parent support group that is part of a preventive mental health intervention in an urban Head Start?
2. By what processes does the parent support group meet its participants' needs?

## THEORETICAL FRAMEWORK

### A social capital framework

We can examine the content and process of this support group in the context of social capital, or resources exchanged within networks of relationships (Bourdieu, 1986). Education research has identified the positive association between parents' social capital and children's academic outcomes in elementary and high school (Lareau & Horvat, 1999; Louie, 2001) and later parent involvement in elementary and middle school (Sheldon, 2002; 2007). One Head Start study to date has used social capital as a framework to analyze the characteristics of families enrolled in a rural Head Start program (Harr, Higgins, & Russell, 2001). In related work, Small (2009) conducted a comprehensive study of childcare programs and suggests that community-based organizations including Head Start serve an important function in facilitating the exchange of

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<sup>1</sup> These seven outcomes include (1) family well-being, (2) parent-child relationships, (3) families as lifelong educators, (4) families as learners, (5) family engagement in transitions, (6) family connections to peers and community, and (7) families as advocates and leaders (Head Start Resource Center).

social capital by allowing members, particularly mothers, the potential to develop relationships with other mothers and staff members and thereby gain the opportunity to exchange resources.

Despite the power of social capital to support achievement and advancement, however, not all networks are equal in their potential to provide resources or influence (Bourdieu, 1986). An individual's ties with members in his or her own immediate network (e.g., family or friends) might be "stronger" (Granovetter, 1973) than those with members of a different network, but such "bonding" capital (Putnam, 2000) may be more effective in conferring emotional support rather than new information, which is more likely to be gained through "bridging" social capital. In other words, as Putnam (2000) has described, bonding ties are good for getting by while bridging ties are good for getting ahead.

The present study contributes to the body of research on social capital in Head Start by describing how a parent group takes its members from "potential" to "actual" support. In particular, the findings highlight three important components of the group that were managed by a facilitator: (1) resources specific to member needs; (2) peer relationships; and (3) appropriate space. Furthermore, the facilitator style was important in encouraging parents to engage in and benefit from the group.

## REVIEW OF LITERATURE

### Head Start family demographics: The effect of poverty and racial or ethnic minority status on parent well-being and child outcomes.

Recent enrollment data show that most Head Start families live in low-income situations and represent racial- or ethnic- minority groups. Per Head Start policy, enrolled families' gross income must not be more than 100% of the Federal Poverty Guidelines (U.S Department of Health and Human Services, 2011), and of children entering Head Start for the first time in 2009, greater than 70% were some race other than White while 36% were Hispanic (Hulsey, Aikens, Kopack, West, Moiduddin, & Tarullo, 2011). These demographic characteristics are associated with residence in unsafe neighborhoods that may limit children's mobility (Furstenberg & Hughes, 1995; Leventhal & Brooks-Gunn, 2000), disconnected neighborhoods that lack the social cohesion that motivates members to act for the common good (Sampson, Raudenbusch, & Earls, 1997), diminished access to material resources that support child development (Duncan & Brooks-Gunn, 2000), and negative educational achievement (Halpern-Felsher, Connell, Spencer, Aber, Duncan, Clifford, et al., 1997).

In addition to the risk factors described above, a particularly important risk associated with poverty and racial or ethnic minority status is depression. Thirty-one percent of adults in poverty report that they have been diagnosed with depression at some point compared with 15.8% of adults not in poverty (Centers for Disease Control, 2010; Brown, 2012). Maternal depression in particular is more common than depression among fathers (CDC, 2010). The implication of depression in mothers is particularly important because of its impact on the mother-child relationship. Research has consistently shown that mothers who are depressed tend to have more trouble being attentive and emotionally involved with their children (Cummings & Davies, 1994; Mustillo, Dorsey, Conover, & Burns, 2011; Turney, 2011; Valdez, Shewakramani, Godlberg, & Padilla, 2013), and they are less likely to be involved at home or at school in ways that support their children's learning and development (Valdez et al., 2013). As a result of

disrupted patterns of mother-child interaction, children of depressed mothers are more likely to have trouble academically and socially at school (Valdez et al., 2013), and they are more likely to display internalizing and externalizing behavior difficulties of their own (Anderson & Hammen, 1993; Beardslee, Versage, & Gladstone, 1998; Elgar, Mills, McGrath, Waschbusch, & Brownridge, 2007; Piche, Bergeron, Cyr & Berthiaume, 2011).

Beyond income, racial or ethnic minority status may also compound a Head Start parent's risk of experiencing depression. Clinical research suggests that minorities are more likely than others to experience chronic depression (see DeJesus Diaz, Gonsalves, & Carek, 2011 for review). Two recent epidemiological studies have further shown that Latinos and Latinas reported the second highest depression prevalence rate (4.3% and 17.7%, respectively) after Whites (Dunlop, Song, Lyons, Manheim, & Chang, 2003). Among immigrant Latino adults from Central and South America in particular, rates of depression are higher than among White adults (Alegria, Canino, Shrout, Woo, Duan, et al., 2008). Head Start does not gather data on immigration status in its families, but the challenges associated with immigration, including the loss of social support as well as a changes in family roles (Comas-Dias, 1990; Zhang & Ta, 2009) overlap with the social isolation and discrimination that may come with ethnic minority status regardless of immigration status.

An important caveat to these data is the fact that the association between maternal depression and child adjustment is not necessarily causal. It could be that child behavior contributes to depression or that other variables may be involved in the association (Lovejoy, Graczyk, O'Hare & Neuman, 2000). Regardless of the mechanisms at work, however, Head Start demographics alone suggest that practitioners are likely to encounter mothers who either have or are at risk for depression. Indeed, evaluation of the impacts of Early Head Start found that almost 50% of the 3,001 low-income mothers who were eligible for EHS displayed symptoms of depression (Administration on Children, Youth, and Families, 2001; Love et al., 2002). Therefore, it is important that programs provide parents with opportunities to buffer the risk of depression.

Opportunities for parents to build social support can serve this buffering purpose. As an interpersonal, reciprocal exchange of information, social support is based in social networks and in a specific context (Finfgeld-Connett, 2005). It contributes to an individual's mental wellbeing by providing people with an opportunity to get to know others and to identify and exchange useful resources (Bronfenbrenner, 1979; Cochran, Lerner, Riley, Gunnarsson, & Henderson, 1990; Simich, Beiser, & Mawani, 2003). Social support can specifically contribute to adaptive parenting when parents learn from others ways to support their children and change negative parenting practices (Osofsky & Thompson, 2003). Maternal support in particular is associated with child adjustment in school (Short & Johnson, 1997), and for immigrant families, social support may help families adapt to new neighborhoods and community institutions such as schools and social service organizations (Fram, 2005). Adaptation may take years beyond the point of immigration to a new country (Deaux, 2006) with some mental health experts suggesting that there are multiple dimensions of adjustment, including behavioral, intellectual, representative, and emotional (Ebata, 2002). Immigrants can benefit from programs that offer either sustained support or a strong foundation from which a person can build additional support.

Social support can be shared in a variety of formats, ranging from verbal to nonverbal and formal to informal. A challenge for a comprehensive service provider such as Head Start is to know the best format for its enrolled families. Indeed, not all parents are willing to seek or accept support from institutions. Whereas depression rates among Latinos are higher than in

other ethnic groups (Dunlop et al., 2003), U.S.-born Latinas are less-likely than U.S.-born White women, immigrant African women, or immigrant Caribbean women to want mental health treatment (Nadeem, Lange, Edge, Fongwa, Belin & Miranda, 2007). Some research has explained this reluctance with a widely held belief in *familismo*, a belief that encourages families to try to take care of themselves (Pescosolodido, Brooks-Gardener, & Lubell, 1998). Furthermore, immigrant women in general, regardless of race or ethnicity, appear to feel a stigma attached to mental health treatment (Nadeem et al., 2007). Parents from ethnic minority groups and low socio-economic status groups more likely to follow-through with parent education programs if the setting and content match their world views and addresses a need for validation and sharing of common experiences (Simich et al., 2003). Latinos, in particular, may be more likely to attend informal as opposed to highly structured groups (Martinez, 1986), and they are more likely to attend if the experience is open to including other family members. A social support group with an informal, face-to-face format meets these criteria.

### Prior parent group research

A parent support group per se may be distinguished in research literature as “a method of practice and a strategy for delivering parenting education<sup>2</sup> and family support,” while also helping parents reduce isolation, develop a community of learners (Carter & Harvey, 1996, p.3) and become their own advocates (Weissbourd & Kagan, 1989). From loosely structured groups that require little feedback from parents to highly structured groups that provide services requiring a clinically trained expert, parent support groups exist in a range of contexts, including clinical settings, community-based organizations, and schools. Each group format calls for a particular kind of leadership style, ranging from non-directive to facilitative to highly structured (Campbell & Palm, 2004). A facilitative group leader, incorporating some qualities of the other two styles, is responsible for the group overall, but he or she allows parents to play active roles in the process, making their own decisions about how the group proceeds and what topics are discussed (Campbell & Palm, 2004). While there exists such a framework for group design, no research to date has analyzed the content and process, or the “what” and “how,” of a loosely structured support group in Head Start or of a group for Latina mothers.

A few studies have specifically investigated school-based parent support groups, but the results are not immediately applicable to early education. Schools often provide curriculum-based parent education groups, and studies of such groups are often evaluative, using treatment/control designs to measure the outcomes of the groups on parenting behavior and/or child cognitive achievement. For example, Baydar, Reid, & Webster-Stratton (2003) investigated the factors that predict maternal engagement in the Incredible Years Parent Training Program among mothers whose children had not been referred for clinical services. Their findings endorse the purpose of such groups, noting that all mothers who participated in the program reported lower negative parenting and higher positive parenting scores compared with mothers in a control group (Webster-Stratton, Reid, & Hammond, 2001). Yet, from these findings, it's not

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<sup>2</sup> Parenting education is defined by National Parenting Education Network (1999) as “a process that involved the expansion of insights, understanding, and attitudes and the acquisition of knowledge and skills about the development of both parents and their children and the relationships between them.” (NPEN, 1999 as cited in Campbell & Palm, 2004, p 17 – 18).

clear how mothers made meaning of the content of the group. Furthermore, this highly structured group focuses on parent-child interaction more so than on parent support.

One investigation by Greif (1993) documents the content and process of long-term support shared among members of a loosely structured parent support group for African-American parents in a Baltimore elementary school. Greif reports that membership in the group ranged from six to fourteen members, and parents often led discussion topics including dealing with difficult children, keeping children protected from negative influences, financial struggles, personal stress and racial discrimination. Greif's study highlights the importance of active participation and support that is uniquely tailored to parents' needs. The findings from the study are further buttressed by research outside of the educational sphere suggesting that one benefit of group membership is conferred through meeting peers who are in similar situations and being able to share stories (Smith, Gabard, Dale & Drucker, 1994). It is not clear whether such uniquely tailored support and the opportunity to share stories would be salient to a parent support group for Latina mothers of young children.

Finally, although it is a rarely studied component of support groups, the actual space in which a group takes place appears to have an impact on the group members' response. Before any work can take place, a group needs a physical space in which to meet (Wuthnow, 1996). A positive physical space is important to a member's mental wellbeing (Sainsbury Centre for Mental Health, 2000) and to a member's comfort level with participation (Wuthnow, 1996). In an age of innumerable opportunities for online group membership, group interaction still appears to benefit from face-to-face communication (Kiesler & Cummings, 2002). Once again, whether these trends emerge in an informal parent support group for Latina mothers of young children is not clear.

## Relevance of this study and research questions

Research clearly suggests that maximized social support among parents facing poverty or social isolation can help strengthen parenting, ultimately helping children receive the best possible support for cognitive, social, and emotional development. Among immigrant parents in particular, social support is important in the transmission of social capital, or resources exchanged within relationships to help parents adapt to new communities and achieve goals for themselves and their families. As Head Start sees changes in the demographics and needs of the families it serves, understanding the expressed needs of its families as well as the process of support may help programs more tightly align their programming with parents' desires and capabilities. In that spirit, two research questions guide this study:

1. What constitutes support from the perspectives of key players in a parent support group that is part of a preventive mental health intervention in an urban Head Start?
2. By what processes does the parent support group meet its participants' needs?

## RESEARCH METHOD

### Case Study Rationale

Because the unit of analysis in this study was the parent support group, and our goal was to report norms of the group, we chose to conduct a descriptive case study (Merriam, 1998). We believed it was important to examine participant interviews in the context of the larger group, and we drew on several sources of data to answer the research questions (Yin, 1989, p. 17). While this study took place in the context of a larger intervention evaluation, our goal was not to evaluate the group but rather to explain the nature of the group.

### Research Site

At the time of the study, our partner Head Start program enrolled approximately 200 urban families, a large percentage of whom were Spanish-speaking immigrant families. During the year in which this study was conducted, 75% of the children enrolled in the center were Latino, and 24% were Black or African-American. Sixty-four percent of the children were primarily Spanish speaking, 29% primarily English speaking, and 7% spoke a language other than English or Spanish. Approximately 93% of the families were living below the poverty line.

The parent support group was part of Family Connections, a larger preventive mental health intervention program being implemented at the center. The strengths-based intervention program provided twice-weekly, full-day mental health consultation to staff members to help them build capacity to work with families that may have been dealing with depression or related adversity. The mental health consultants also facilitated a parent support group for one hour one morning per week. The group began in fall 2005, and this case study focuses on the group during one academic year, from August 2006 – June 2007. We chose this time frame in order to allow the intervention staff to establish the group in the 2005-6 academic year.

The consultant was the primary recruiter for the group, regularly posting English and Spanish fliers announcing group times and, when they were planned, topics. She also approached parents during drop-off time on Friday mornings. Parents who did not drop their children off at the center would not have been included in these recruitment strategies. Participants were allowed to bring younger children with them, and one mother routinely brought her toddler with her. The group was sometimes advertised as the “Friday Parents’ Group” where parents could share ideas about different topics; it was never advertised as a depression-prevention or support group.

### Participants

Participants in this case study included six parent group members and two group facilitators. Group participation was open, and attendance was not mandatory. Although participant names were not recorded each week, the consultant documented the number of participants in attendance each week, including the number of new participants. Attendance ranged across the year from one to 12 people including parents, grandparents, and Head Start center staff. No one new joined the group after November 17, 2006, however.

The parent interview sample for this present study was both purposeful and convenient. We wanted to talk with the most active participants (Martinez-Cosio & Iannacone, 2007) or those who attended the group on a regular basis because these mothers would best know the group and be able to describe how they made meaning of the group. The consultant identified parents who attended the group regularly, and the first author pre-selected four weeks when it would be convenient to interview them during group time – weeks, for example, when there were no planned guests or when the group was not otherwise postponed because of other center events. The interview sample was further limited to those mothers who were present each day that the first author visited.

The six parents interviewed were all mothers, and, with two exceptions, immigrants from Latin America. One mother was from Puerto Rico, and another mother who was born in mainland US returned to her parents' home of Puerto Rico regularly (see Table 1). For the purpose of this discussion, we incorporate these mothers' experiences with the others, although we do not use their interview data to discuss immigration, per se. Their stories as Latina mothers in this community share similarities with the other immigrant mothers in the group. Of four mothers for whom we did gather length of residence in the United States, all had come to the United States at least four years prior to the interviews (range 4 - 9 years).

TABLE 1  
Demographic information of mothers in interview sample.

<b>Mother's name<sup>3</sup></b>	<b>Birthplace</b>	<b># of Children</b>	<b>Years in the U.S.</b>	<b>Marital Status</b>
Lily	Honduras	2	5+	Married
Dawn	Puerto Rico	1	9	Married
Phyllis	Dominican	3	4	Married
Stacy	Dominican	2	8	Married
Ivette	US (of Puerto	2	Lifetime	Married
Laura	Puerto Rico	3	n/a	n/a

The case study participants also included two Caucasian female mental health consultants, who facilitated the group. One consultant, a licensed clinical psychologist, was not an active facilitator of the group during the 2006-2007 academic year, but she had established the group, and several of the mothers had begun participating with her. The second consultant was a Master's level prevention specialist. Each consultant was fluent in Spanish.

### Data Collection Procedures

In addition to participant interviews, data for this case study also came from mental health consultant reports of events at each group meeting.

<sup>3</sup> All names of mothers in the support group have been changed.



## Facilitator Evaluation Forms

For each group session, the mental health consultants submitted to the intervention evaluation team a "Parent Group Facilitator Evaluation Form." The confidential form asked the consultant to describe what happened in the group session, including the number of participants and topics discussed. The form also asked, "What resources did you share?" from which response we could see what kind of information, or capital, the consultant shared with parents. Finally, the form more broadly asked the consultant to "Provide a general summary of the drop-in group." The response allowed us to see from the consultant's perspective what topics were discussed and how the conversation of the group proceeded. Twenty-five evaluation forms were gathered during the timeframe of this study.

## Interviews

Semi-structured interviews allowed us to learn how each parent and consultant made meaning of the group (Seidman, 1998). The first author conducted each interview except for five of the six parent interviews that were conducted in Spanish by a member of the first author's university community. In these cases, the first author, who had an intermediate proficiency in Spanish, organized and attended the interviews. The author maintained an active presence throughout the Spanish interviews, asking follow-up questions of and chatting informally in Spanish with parents at the beginning and end of the interview. Each interview was conducted in a private space at the Head Start center and audio-recorded. Project research assistants and the first author transcribed the English interviews. A native Spanish speaker from the first author's university community transcribed and translated the Spanish interviews.

We did not have access to the entire duration of the group meetings due to the mental health consultant's concern for parents' confidentiality. We did, however, observe one complete group session and the beginning of a number of group sessions.

## Data Analysis

The first author analyzed interview transcripts through an iterative process of identifying themes and developing codes (Strauss & Corbin, 1990; Maxwell, 1996). She began by open coding, or assigning a descriptive code to every segment of the data set (Lincoln & Guba, 1985). These codes captured the face value of the data (e.g., duration in group; parents help one another outside of group; topic: religion, immigration; group space; confidence in facilitator). She conducted this first step to make sure to account for any unexpected themes and to prepare data for the next stage of coding. In the next stage of coding, she approached the data with *a priori* codes that captured concepts in the framework. These included, for example, "motivation," "support," and "group process." She then sub-coded those themes into categories reflected in the data, including "immigration," "self-care," "parenting," and others. She entered all interview documents and codes into *ATLAS.ti* and generated coding reports to assist in writing about the findings.

To address the Facilitator Evaluation Forms, the first author coded each form for topic (e.g., learning disabilities). She entered the topic codes into an Excel document and, after

reviewing the codes, grouped them into four broad categories: *parenting*, *economic situation*, *immigration*, and *goals*. These categories frame the findings below and are presented in more detail in Table 2 (See Appendix A).

## Validity

The first author used several strategies to strengthen the validity of this study. During the data gathering stage, to address her “outsider” status as a non-Latina and non-mother, she relied on the support of the mental health consultant who vouched for her with parents in the group. In the interviews, the interviewer reassured participants that we wanted to understand how the group was working, and that the facilitator would not know what any one mother said. During the data analysis stage, she also triangulated data by looking at different sources: interviews, fliers, bulletin board notices, and field notes. She presented analysis and drafts of writing to members of a writing group who helped challenge interpretation and assumptions.

## FINDINGS

Findings from this study highlight challenges that low-income Latina mothers of young children in one community had to address as well as the process by which resources and relationships promoted their address of such challenges. In particular, mothers’ reported benefitting from the group through developing close relationships and exchanging resources related to parenting, economic challenges, immigration, and personal wellbeing during group time. Group process included the dynamic interplay of relationships, resources, and space, managed by a facilitator. In this section, we first illustrate the salience of parenting, economic challenges, immigration, and personal wellbeing to the participants. We then describe the model by which these issues were handled in the group.

*What constitutes support from the perspective of key players in a parent support group that is part of a preventive mental health intervention in an urban Head Start?*

### Parenting Resources

The strongest theme in the mothers’ discussion from week to week was their deep commitments to parenting. They sought resources about specific topics rather than education to address parenting insecurities. While they did talk about discipline strategies or how to talk about difficult topics with children, they approached these topics from points of strength and proactive anticipation of their children’s behavior and needs. They also discussed learning disabilities most often. Every mother, for example, reported benefitting from a visit by a social worker who spoke with the group about autism. None of the mothers interviewed had a child with autism; however, most of them reported feeling better about having the knowledge for the sake of helping their friends. As Laura explained, “I have a friend who has a son with autism, so I gave her some information. I have noticed some kids who are, you know, active, and I have seen some

signs of kids having ADHD, and I have talked to their parents to get information from their doctors.” When asked what she liked best about the group, Phyllis said:

The topics that we deal with . . . For example, the other day there was someone who was talking about autistic kids, and then some of us were not very clear about it. Because someone knows things meaning, “being autistic is this,” but for someone to know about things more in depth, then I like that.

## Economic Resources

Problems related to mothers' low-income status were common in the group, and support was once again related to resources and relationships. Most economic support filled a gap in information. For example, recurrent topics included affordable places to take children in the summer, violence in low-income neighborhoods, and housing concerns. Resources most often came in the form of fliers, handouts, or verbal exchange of information about community resources and activities, which mothers reported liking and actively using. For example, Laura explained:

You know, when the summer is coming, they talk about places to go with your kids that I sometimes don't know about, or events you know that you can take your children to – theaters and aquarium, free of charge. Sometimes people don't know they exist for us to be used . . . They [consultants] can really give us information, and we can use it. In several cases, they also reported taking these outings together, thereby extending their relationships outside of the group. The mothers commonly supported one another through neighborhood and housing concerns. From dissatisfaction with their own housing situations to concern for their children's safety in the broader community, it was clear that the mothers were frustrated with a lack of safety in their communities and that finding comfort in one's own home was sometimes difficult. As one facilitator evaluation form documented:

One mom arrived early and entered the room beaming and with great news on her housing situation: it has been quiet all week and her family has been able to sleep. For some reason, her aggressively disturbing neighbor has been laying low. We talked about great she feels getting peace and quiet in her home.

Other reasons for support were more serious than noisy neighborhoods. Violence in the community was particularly high during the time of this study, and it came up in the group throughout the year as the facilitator evaluation form documented:

Last week, she told me her sons had been shot at, so I asked her how they were doing. She said they are getting therapy through their schools. She attended a meeting on violence in the community. We talked about inviting a police office to [our group] to hear from families about the violence that is affecting them.

## Immigration Resources

Similar to their feelings about neighborhood safety, mothers reported feeling a lack of voice in their immigration statuses. Their stories related to immigration status largely reflected difficulties

in raising their children in a different culture and in isolation from their families. A larger national immigration debate weighed on their minds:

I raised the current news about immigration, and asked the group their feelings about the state troopers possibly being given authority to arrest illegal immigrants. I raised the topic so that we could talk through the information that we have, rather than walking around in fear. (I mentioned that while [current Governor] has said ok to this, [Governor-elect] does not support it, and it may not go through after all).

Stacy took comfort in the group's informational support:

You . . . have many ways of helping us . . . right now, I'm waiting, supposedly, until they release that law they're about to approve about immigration. And [the mental health consultant] once brought a lawyer that gave me information that I didn't know and wasn't going to have a way of knowing.

The mothers talked often about being parents in the different culture of the United States. As primary caretakers, they communicated with schools and other community organizations and helped their children navigate these environments even while they themselves were learning how the organizations operated. The most recent immigrant, Phyllis, had come to the United States four years prior to the study. Yet, with each stage of their children's lives, they were experiencing a new, unfamiliar situation. Lily, for example, worried about protecting her children:

There are times when we [the group] talk about how we saw some TV program. We comment on it and how here we have to watch out for our kids so that they don't go with strangers and everything. Even though we talk to them, and we think that we are sure that they're never going to do it, we have seen TV programs, and we know that kids always do it.

Similarly, Stacy's concern for her daughters reflects both her adaptation to U.S. norms around childrearing and her daughters' experiences:

My husband and I fight until the end to protect them so that nothing happens to them, which is bad in part because protecting them here is bad because all the time you're giving to them, and they don't know. If you take care of them, it's bad, and if you leave them on the streets, it's worse because if they do something in the street, the one responsible is the parents. If you punish them, and they say in school, 'my mom . . . punishes me,' that's also bad because you're maltreating them. They understand it here as abuse.

Besides concern for their children, the mothers also expressed frustration with their own lack of family in the US, and they felt that the group was like family. For example, Phyllis said, "I saw that it [the group] was like a family . . . and that's why I've always continued coming." Stacy had similar feelings: "Here, in this country . . . I don't have family, and I feel very alone. Here in the group . . . I've met many people. I'm very close to them, and I feel like they're part of my family now . . . Then, because we spend time together and such, I've felt really good." The group may be her only source of relationships:

It's very hard here in this country with the children. It's very, very hard because . . . here in the country, you can't trust anybody. I don't trust anybody to be able to leave my

daughters with them. I don't go out, and if I go any place, any day of the year, my daughters are with me. I go to the hospital, and my girls are with me. I gave birth, and my daughter had to be in the door in order to be able to stay because I don't have anybody to take care of her.

While all mothers reported that the group was like a family, and they sometimes went on outings together with their children, they also described clear boundaries around their relationships with one another. When asked whether she and the mothers were friends, Stacy replied, "Yeah. We get together, we call each other . . . it's not like in their houses because I don't like it, not me not my girls, I don't teach them to be inside others' houses." Ivette reflected similar boundaries when she suggested that the group served as her family when she was not with her own: "So, usually, I meet them [mothers in the group], . . . and from Monday to Friday, they're my family."

With help from the mental health consultant, the group gained momentum over time. When the last new member joined the group in November of the observation year, the mental health consultant recorded surprise at the level of candor in the mothers' introduction to the new member:

Unlike other times we have tried to do introductions for a new person, this time each person carefully introduced herself, saying which classroom her child was in, and also what the group meant to her. People made the following comments:

'this group is like a family to me.'

'I come here for conversation.'

'I don't have family in this country – but I have this family.'

'The moment that I feel strangled, I have this group to turn to.'

It has not been easy to go around the room in an organized way in the past – and something in the mood of the room worked this morning for people to open up . . .the group felt incredibly supportive of one another today."

## Personal Goal Resources

In addition to talking about their children and their communities, the mothers talked about their own wellbeing. As the mental health consultant put it, "We also talked about our roles in our families and what we "take on" as women." The degree of support around these topics varied. Sometimes, people just shared their plans and gathered encouragement from the group. For example, as the mental health consultant documented, "a regularly attending Mom came by and talked about her plans to enroll in an English class. She spoke about planning to take her children to a YMCA afterschool program so that she would be free to take classes." In other cases, the group played a more important role:

One Mom, who is a regular volunteer at [Head Start] . . .began talking to me . . . 'I don't know what's wrong with me; I just didn't want to get out of bed this morning.'" As we continued to talk, she told me her husband was sent (back) to jail in [nearby town], and she wanted to visit him but couldn't remember how to get there. We got online and looked up commuter rail information and . . . the route to the jail from the station. We spoke about all the recent changes in her life, and I asked her about her social worker and supports available to her through her

family.

Having this time to talk about themselves seemed to normalize their challenges and build resilience to them. As Dawn expressed, “you hear other people and other parents and you say, ‘whoa,’ and that helps. You say, ‘I’m not alone . . . .’”

*By what process does the parent support group meet its participants’ needs?*

### Setting the space

Each week, the mental health consultant arrived early to convert a conference room in the center space to a private meeting space set apart from the rest of the center, and this conversion became an important backdrop to the parents’ experience. On several visits, the first author observed her do the preparatory work of laying out a tablecloth and food and arranging chairs in a circle, away from the conference tables. After setting the space, she engaged in the relational work of greeting parents, either in the doorway or just in front of the larger group circle to greet parents one-by-one. When asked whether they thought of a better space for the group meeting, none of them said they did. One mother reported liking the convenience of being able to stay after dropping off her children and to be close to them.

### Facilitative Group Leadership

Comments from the mental health consultant about her approach to the group begin to support the notion that she used a facilitative style (Campbell & Palm, 2004) wherein she drove the group process but also provided a lot of room for participant decisions about the content:

Our motto has always been to follow what comes from the group itself...We listen to what their needs are, follow up by bringing resources the following week by saying, ‘you know, some of you mentioned not having a lot to do on the weekend, or finding things that are free, so here are things that are free.’

While the consultant most often led the need for resources, sometimes the exchange was parent-initiated. As Phyllis reported:

It’s that sometimes in these groups, one finds out about things [that] in the streets it’s harder to find out . . . for example, I find out something and I say, ‘hey, I found out about this,’ and . . . we ourselves, . . . in the group had made the understanding that if I see something, and this is of use for the group, I’ll take it. If I go to a place and I see a flyer, ‘oh, let me take this,’ then it gives the opportunity for everybody to find out about everything.”

The consultant described how the group format provided a level of support that went beyond simply having like-minded mothers in the same room:

I think that, sure, there are ways that it’s very similar to talking to a friend, but I think the difference would be helping parents with what feels like a dead end or something really

overwhelming and taking that and moving it to action, and finding strategies, and finding ways to shift gears so that you don't feel frozen and overwhelmed but you can do something about it. And I think that while friends can provide that support, it may not be with the same conversation, and we have the aim and goal that we have to do that.

## DISCUSSION

Overall, social capital in this group was most frequently an answer to questions or concerns about parenting in low-income neighborhoods, in being an immigrant or ethnic minority, and in wanting to take care of oneself for the sake of one's children.

In addressing safe and affordable places to go with children, the group helped open up access to unknown information and, potentially, benefit children's developmental outcomes (Furstenberg & Hughes, 1995; Leventhal & Brooks-Gunn, 2000). In several interview examples, it was clear that a mother's views on childrearing differed from the U.S. norm, a conflict endorsed often in immigration research (Deaux, 2006; Suarez-Orozco & Suarez-Orozco, 2002), and while group participation did not necessarily change someone's views on childrearing, it gave mothers a community of empathetic listeners (Simich, 2003). This community may be seen as a benefit in and of itself as maternal emotional wellbeing lays a stronger foundation for positive parenting and, by extension, child outcomes (Mustillo, Dorsey, Conover, & Burns, 2011; Petterson & Albers, 2001; Webster-Stratton, 1990).

Overall, the support group demonstrates ways in which the mothers took advantage of the potential to exchange social capital (Small, 2009) and ways in which both weak ties and strong ties (Granovetter, 1973) were at work. Mothers most often gained information through "weak ties" with either the mental health consultant or an expert brought into the group, as in the case of autism education. They often then went on to apply that information in their lives with family and friends following a sense of empowerment gained from the group, (Weissbourd & Kagan, 1989). There were also times when close ties among the mothers profited the group as happened when they themselves brought in resources for each other without any activity from the facilitator. In these cases, as well as when they simply validated each other's experiences without any materials, their shared experiences allowed them to be bona fide resources for each other (Simich et al., 2003).

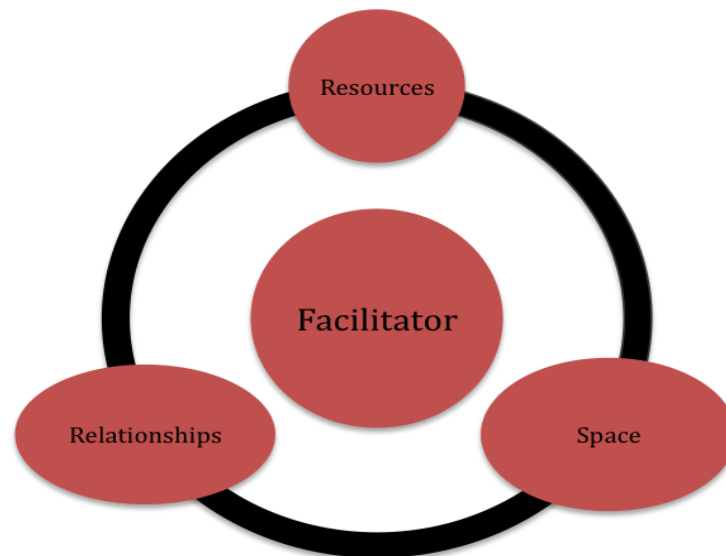
Throughout group meetings, the mental health consultant maintained a facilitative style, responding to mothers' requests for information and moderating conversation each week (Campbell & Palm, 2004). Her preparatory work to set up the room for the group reflected the importance of having a comfortable space (Wuthnow, 1996), and by providing a positive and inspiring space for sharing support, the converted space reflected a core characteristic of effective social service agencies (Sainsbury Centre for Mental Health, 2000). The mental health consultant role aligned well with that of an institutional agent (Stanton-Salazar, 2011; Stanton-Salazar & Dornbusch, 1995) who mediated mothers' access to resources. In bringing relevant community-based resources to the group, she demonstrated a solid knowledge of community resources, an important competency in a support group leader (Kurz-Riemer, 2001 as cited in Campbell & Palm, 2004).

It is also important to emphasize that it did not attempt to go beyond the limits of what it could realistically and responsibly offer to mothers. The mental health consultant had some level of expertise and clinical training, as well as training in the Family Connections intervention in

which the group was embedded. Yet, such training was not a pre-requisite of running the group. Instead, what was important was her knowledge of the community, knowledge of child development, and insight to know when a mother or the group might have needed more intensive or skilled support.

Given the fact that stigma about receiving mental health services is more common among women than men, and the fact that women with depression as opposed to those without it are less likely to seek help because of stigma (Nadeem et al., 2007), a leader with a facilitative style (Campbell & Palm, 2004) could be key to helping women who otherwise would not seek or receive resources get what they need. This kind of facilitator could not only provide or connect a mother to relevant resources, but she could also help reduce stigma associated with mental health care and thereby increase the likelihood that an otherwise reluctant mother would be willing to seek intensive services if necessary.

Although the findings described in this study may not be generalized beyond the time and place of the group, they allude to a more general model for a parent support group that may be applied to any local context. As described, the group appeared to thrive through three dynamically linked components –relationships, resources, and space – whose interplay was managed by a facilitator (see Figure 1). With a mental health consultant as facilitator, the mothers exchanged and actually applied new resources in the context of their relationships with each other and within an authentic, safe space apart from the rest of the center.



*Figure 1.* Support group model of dynamic interplay of relationships, resources, and space as mediated by group facilitator.

Despite the potential gain in relationships and resources that this model predicts, it is also important to recognize potential tensions inherent in it. Social capital has its limits (Portes & Landolt, 1996), and in a group model such as this, limits existed in the role of the facilitator and in the exclusive quality of the relationships and resources the group fostered.

Martinez-Cosio and Iannacone (2007) highlight the tension that can arise when an institutional agent serves multiple, potentially competing roles. Being a bridge between the



dominant culture and parents' cultures as well as an agent of the employing institution can make the role of facilitator complicated. In this group, the facilitator was an ally of the mothers, yet she represented both the mental health intervention and, by extension, Head Start. If parents' needs for support conflicted with Head Start's ability to support them, the facilitator had to try to meet needs on both sides of the divide. This tension also illustrates the fragility of weak ties (Granovetter, 1973). If, in the face of potential conflict, a facilitator had to act on her allegiance to the institution over the group's wishes, the weak ties would not be strong enough to sustain the group's wishes.

While the resources and relationships negotiated within the space reflect local context and authentic need for support, they also reflected boundaries to the outside. This group evolved into a meaningful source of support for Latina mothers. It is beyond the scope of the data to know how the mothers felt about their common ethnicity and language, or how other parents in the center perceived the group. But, it is possible that they group would have been less valuable as a source of support for non-Latina or non-Spanish-speaking parents. This exclusivity was perhaps necessary for the group to be meaningful to its participants; however, a center implementing this kind of parent support group would want to recognize this tension between deeply meeting the needs of a few people versus shallowly meeting the needs of many.

Finally, a related limitation is that the group really only reached women who were took the initiative to attend it. The needs of mothers and other primary caregivers who need support but who are less willing to participate in a group or reach out for other help may go unaddressed. This kind of group should be seen as a buffer to the risks associated with poverty and racial/ethnic minority status and not more than that. However, this kind of group has the potential to reach many in just the place they need support.

## LIMITATIONS AND FUTURE

This study contributes to the wider body of research on parent support in Head Start, particularly support of Latina mothers. It proposes a model for an informal support group that could be implemented without requiring too much strain on a center's budget or staff. The study also has several limitations that future research might address.

First, although this study was not an evaluation, nor was it meant to focus on individual effects, it would strengthen our understanding of the group process if we had data that spoke to each participant's change over time, both during participation in the group and afterwards. In particular, a future study might examine whether and how relationships and resources from the group sustained their relevance to the mothers after they left Head Start. A future study might also directly assess child outcomes that may be linked to mothers' participation in the group.

Similarly, while we had a substantial amount of field notes from the center, the number of group observations was limited. Out of the facilitator's concern for the parents' privacy, we did not sit in on groups as often as would have been ideal, and when we did sit in on a group, it was near the end of the year, after the group had had a chance to coalesce. Understanding the early stages of the group process would have allowed us to understand more deeply how group evolved over time into the model that we propose. A future study might negotiate long-term access to the group to get more detailed process data to inform this model.

Finally, the single-case design of the study limits the generalizability of findings beyond the center and immediate community. A future study might examine themes across several

groups to see what, if any, commonalities emerge across sites and thereby strengthen the implementation of future groups.

## CONCLUSION

Viewing a group through the lens of relationships and resources, or social capital, highlights the important components and the process underlying the work of the group. These findings extend prior research by showing how a community-based organization such as Head Start can serve as a site of social capital (Small, 2009) for immigrant mothers in particular, pointing to a model of support that is flexible and organic, building on mothers' strengths and responding to mothers' own expressed needs. In this support group, the social capital was uniquely generated by and for the Latina mothers who routinely participated in the group. As such, the findings may not be generalized beyond the scope of the group. The unique construction, however, took place within a framework that other centers might apply: a dynamic interplay of relationships, resources, and space, managed by a facilitator who can both advocate for the group members and bring external resources to bear on the group as needed. Providing a forum for parents to build relationships and negotiate support may help centers ensure that their parents' needs are being met as appropriately as possible.

## REFERENCES

- Administration on Children, Youth, and Families. (2000). Evaluation of Head Start Family Child Care Demonstration: Final report. Commissioner's Office of Research and Evaluation. Washington, DC: Author. Retrieved April 15, 2010 from <http://www.researchconnections.org/childcare/resources/1035?state=ARKANSAS&paging.startRow=1&publicationYear=2000>.
- Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D., et al. (2008). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry*, *165*(3), 359-69.
- Anderson, C.A., & Hammen, C.L. (1993). Psychosocial outcomes of children of unipolar depressed, bipolar, medically ill, and normal women: a longitudinal study. *Journal of Consulting and Clinical Psychology*, *61*, 448 – 454.
- Baydar, N., Reid, J. M., & Webster-Stratton, C. (2003). The Role of Mental Health Factors and Program Engagement in the Effectiveness of a Preventive Parenting Program for Head Start Mothers. *Child Development*, *74*(5), 1433 – 1453.
- Beardslee, W. R., Versage, E., & Gladstone, T. R. G. (1998). Children of affectively ill parents: A review of the past ten years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *37*, 1134–1141.
- Beardslee, W. R., Ayoub, C., Watts, C. L., Avery, M. W., & O'Carroll, K. L. (2010). Family Connections: An Approach for Strengthening Early Care Systems in Facing Depression and Adversity. *American Journal of Orthopsychiatry*, *80*(4), 482-495.
- Bourdieu, P. (1986). The forms of capital. In J. Richardson (Ed.), *Handbook of theory and research for the sociology of education* (pp. 241-258). Westport, CT: Greenwood Press.
- Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.
- Brown, Alyssa. (2012). With poverty comes depression, more than other illnesses. Gallup Wellbeing. Retrieved March 7, 2012 from: <http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx>.
- Campbell, D., & Palm, G. F. (2004). *Group parent education: Promoting parent learning and support*. Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781452232423.
- Carter, N. & Harvey, C. (1996). Gaining Perspective on Parenting Groups. *Bulletin of Zero to Three: National Center for Infants, Toddlers, and Families*, *16*(6).

- Centers for Disease Control (2010). Current Depression Among Adults. Morbidity and Mortality Weekly Report: United States 2006 and 2008. Retrieved from [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5938a2.htm?s\\_cid=mm5938a2\\_e](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5938a2.htm?s_cid=mm5938a2_e).
- Cochran, M., Larner, M., Riley, D., Gunnarsson, L. & Henderson, C. R. (Eds.) (1990). *Extending families: The social networks of parents and their children*. Cambridge, England: Cambridge University Press.
- Comas-Dias, L. (1990). Hispanic/Latino communities: Psychological implications. *The Journal of Training and Practice in Professional Psychology*, 4(1), 14 – 35.
- Cummings, E. M., Davies, P. T. (1994). Maternal depression and child development. *Journal of Psychological Psychiatry*, 35(1). 73 – 112.
- Deaux, K. (2006). *To be an immigrant*. New York: Russell Sage Foundation.
- DeJesus, S. A., Diaz, V. A., Gonsalves, W. C., Carek, P. J. (2011). Identification and treatment of depression in minority populations. *International Journal of Psychiatry Medicine*, 42(1), 69-83.
- Duncan, G. J. & Brooks-Gunn, J. (2000). Family poverty, welfare reform, and child development. *Child Development*, 71(1), 188 – 196.
- Dunlop, D. D., Song, J., Lyons, J. S., Manheim, L. M., & Chang, R. W. (2003). Racial/ethnic differences in rates of depression among preretirement adults. *American Journal of Public Health*, 93(11). 1945-1952.
- Ebata, K. (2002). *Seishin Shinkeigaku Zasshi*, 104(4), 278-91.
- Elgar, F. J., Mills, R. S. L., McGrath, P. J., Waschbusch, D. A., Brownridge, D. A. (2007). Maternal and paternal depressive symptoms and child maladjustment: the mediating role of parental behavior. *Journal of Abnormal Child Psychology*, 35, 934-955.
- Finfgeld-Conett, D. (2005). Clarification of social support. *Journal of Nursing Scholarship*, 37(1), 4-9.
- Fram, M. S. (2005). "It's just not all teenage moms": diversity, support, and relationship in family services. *American Journal of Orthopsychiatry*, 74(4), 507 – 17.
- Furstenberg, F. F. & Hughes, M. E. (1995). Social capital and successful development among at-risk youth. *Journal of Marriage and the Family*, 57, 580-592.
- Granovetter, M. (1973). The strength of weak ties. *American Journal of Sociology*, 78, 1360-1380.
- Greif, G. L. (1993). A school-based support group for urban African-American parents. *Social Work in Education*, 15, 133-139.
- Halpern-Felsher, B., Connell, J. P., Spencer, M. B., Aber, J. L., Duncan, G. J., Clifford, E., Crichlow, W., . . . Cole, S. S. (1997). Neighborhood and family factors predicting educational risk and attainment in African American and White children and adolescents. In Brooks-Gunn, J., Duncan, G. J., & Aber, J. L. (2000). *Neighborhood Poverty: Vol. 1. Context and Consequences for Children*. New York: Russell Sage Foundation.
- Harr, J., Higgins, S., & Russell, P. (2001). Characteristics of families enrolled in an isolated, mountain Head Start program: Managing social capital. *Issues in Comprehensive Pediatric Nursing*, 24, 117–135.
- Head Start Resource Center. (2011). Office of Head Start, Administration for Children and Families. Arlington, VA: U.S. Department of Health and Human Services. Retrieved March 16, 2013 from <http://eclkc.ohs.acf.hhs.gov/hslc/standards/IMS/2011/pfce-framework.pdf>. H.R. 1429: Improving Head Start for School Readiness Act of 2007. Retrieved May 24, 2009: <http://www.govtrack.us/congress/bill.xpd?bill=h110-1429&tab=summary>.
- Hulsey, L. K., Aikens, N., Kopack, A., West, J., Moiduddin, E., and Tarullo, L. (2011). Head Start Children, Families, and Programs: Present and Past Data from FACES. OPRE Report 2011-33a. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved May 9, 2013 from [http://eclkc.ohs.acf.hhs.gov/hslc/mr/opre/present\\_past.pdf](http://eclkc.ohs.acf.hhs.gov/hslc/mr/opre/present_past.pdf)
- Kiesler, S. & Cummings, J. N. (2002). What do we know about proximity and distance in work groups? A legacy of research. In Hinds, P. & Kiesler, S. (Eds.), *Distributed Work* (57-82). Cambridge: MIT Press.
- Kurz-Riemer, K. (Ed). (2001). *A guide for implementing early childhood education programs*. Roseville: Minnesota Department of Children, Families, and Learning. In Campbell, D., & Palm, G.F. (2004). *Group Parent Education: Promoting Parent Learning and Support*. Thousand Oaks, CA: Sage Publications.
- Lareau, A., & Horvat, E. M. (1999). Moments of social inclusion and exclusion: Race, class and cultural capital in family-school relationships. *Sociology of Education*, 72, 37–53.
- Leventhal, T & Brooks-Gunn, J. (2000). The neighborhoods they live in: the effects of neighborhood residence on child and adolescent outcomes. *Psychological Bulletin*, 126(2), 309 - 337.
- Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. New York: Sage.
- Louie, V. (2001). Fall. Parents' Aspirations and Investment: The Role of Social Class in

- the educational experiences of 1.5- and second-generation Chinese Americans. *Harvard Educational Review Special Issue on Immigration and Education* 71(3): 438-474.
- Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. (2000). Maternal depression and parenting behavior: A meta-analytic review. *Clinical Psychology Review*, 20, 561–592.
- Martinez-Cosio, M. & Iannacone, R. M. (2007). The tenuous role of institutional agents: Parent liaisons as cultural brokers. *Education and Urban Society*, 349-369.
- Martinez, C. (1986). Hispanic psychiatric issues. In Gaw, A. C. (Ed.), *Culture, ethnicity, and mental illness*, 431-466. Washington, D.C.: American Psychiatric Press.
- Maxwell, J. A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks, CA: Sage.
- Merriam, S. B. (1998). *Qualitative research and case study applications in education*. San Francisco: Jossey-Bass.
- Mustillo, S. A., Dorsey, S., Conover, K., & Burns, B. J. (2011). Caregiver depression and child mental health: The developmental effects of parenting. *Journal of Marriage and Family*, 73, 164-180.
- Nadeem, E., Lange, J. M., Edge, D., Fongwa, M., Belin, T., & Miranda, J. (2007). Does stigma keep poor young immigrant and U.S.-born Black and Latina women from seeking mental health care? *Psychiatric Services*, 58, 12. doi: 10.1176/appi.ps.58.12.1547.
- Office of Head Start. U.S. Department of Health and Human Services. Administration for Children and Families. (n.d.) Early Head Start Information Folder. Retrieved July 11, 2006, from [www.headstartinfo.org/infocenter/ehs\\_tkit3.htm](http://www.headstartinfo.org/infocenter/ehs_tkit3.htm).
- Osofsky, J. D. & Thompson, D. (2000). Adaptive and maladaptive parenting. *Handbook of Early Childhood Intervention* 2<sup>nd</sup> ed., p. 54 – 75.
- Pescosolido, B. A., Brooks-Gardner, C., & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion and 'muddling through' from 'first-timers.'" *Social Science and Medicine* 46(2), 275-286.
- Pettersson, S. M. & Albers, B. A. (2001). Effects of poverty and maternal depression on early child development. *Child Development*, 72(6), 1794 – 1813.
- Piche', G., Bergeron, L., Cyr, M., & Berthiaume, C. (2011). Interaction effects between maternal lifetime depressive/anxiety disorders and correlates of children's externalizing symptoms. *Journal of Child and Family Studies*, 20, 596–604.
- Portes, A. & Landolt, P. (1996). The downside of social capital,' *The American Prospect*, 26, 18-22.
- The Sainsbury Centre for Mental Health. (2000). On your doorstep: Community organisations and mental health. London: The Sainsbury Centre for Mental Health. Retrieved March 21, 2013 from [http://www.centreformentalhealth.org.uk/pdfs/on\\_your\\_doorstep.pdf](http://www.centreformentalhealth.org.uk/pdfs/on_your_doorstep.pdf)
- Putnam, R.D. (2000). *Bowling alone: the collapse and revival of American community*. New York: Simon & Schuster.
- Short, K. & Johnson, C. (1997). Stress, maternal distress, and children's adjustment after immigration: The buffering of social support. *Journal of Consulting and Clinical Psychology*, 65(3), 495 – 503.
- Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences*. New York: Teachers College Press.
- Simich, L., Beiser, M. & Mawani, F. N. (2003). Social support and the significance of shared experience in refugee migration and resettlement. *Western Journal of Nursing Research*, 25(7), 872 – 891.
- Small, M. L. (2009). *Unanticipated Gains: Origins of Network Inequality in Everyday Life*. New York: Oxford University Press.
- Smith, K., Gabard, D., Dale, D., & Drucker, A. (1994). Parental opinions about attending parent support groups. *Children's Health Care*, 23(2), 127 – 136.
- Stanton-Salazar, R. D., & Dornbusch, S. M. (1995). Social capital and the reproduction of inequality: Information networks among Mexican-origin high school students. *Sociology of Education*, 68, 116–135.
- Strauss, A. and Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications.
- Suarez-Orozco, C. & Suarez-Orozco, M.M. (2002). *Children of Immigration*. Cambridge: Harvard University Press.
- Tarullo, L., West, J., Aikens, N., & Hulse, L. (2008). Beginning Head Start: Children, families, and programs in Fall 2006. *FACES 2006 Baseline Report*.
- Turney, K. (2011). Labored love: Examining the link between maternal depression and parenting behaviors. *Social Science Research*, 40, 399-415.
- U.S. Department of Health and Human Services. (2011). *The 2011 HHS Poverty Guidelines*. Washington, D.C.: Author. Retrieved May 9, 2013 from <http://aspe.hhs.gov/poverty/11poverty.shtml>.

- Valdez, C. R., Shewakramani, V., Goldberg, S., Padilla, B. (2013). Parenting influences on Latino children's social competence in the first grade: Parental depression and parent involvement at home and school. *Child Psychiatry & Human Development*, 1 -12.
- Webster-Stratton, C. (1990). Long-term follow-up of families with young conduct *Psychology* 19(2): 144-149.
- Webster-Stratton, C., Reid, M. J. & Hammond, M. (2001). Preventing conduct problems, promoting social competence: A parent and teacher training partnership in Head Start. *Journal of Clinical Child & Adolescent Psychology*, 31(3).
- Weissbourd, B., & Kagan, S.L. (1989). Family support programs: Catalysts for change. *American Journal of Orthopsychiatry*, 59, 20 – 31.
- Wuthnow, R. (1996). *Sharing the Journey. Support Groups and America's New Quest for Community*. New York: Free Press.
- Yin, R. K. (1989) *Case Study Research, Design and Methods*, 3rd ed. Newbury Park, Sage Publications.
- Zhang W., & Ta, V. M. (2009). Social connections, immigration status, and health among Asian Americans. *Social Science & Medicine*, 68(12), 2104-12.

## APPENDIX A

TABLE 2  
 Topics discussed in the parent support group as recorded by the mental health consultant in  
 Facilitator Evaluation Forms across 25 weeks  
 from August 2006 – June 2007

Topics	# weeks	% weeks
<b>Parenting</b>		
Being a new parent	7	27%
Learning disabilities	6	23%
School/placement concerns	5	19%
Learning- or health-related resources	4	15%
Talking about difficult topics with kids	4	15%
Discipline	3	12%
Sleep routines for children	2	8%
Child health concerns	1	4%
Center concerns related to child	1	4%
Employment for teens	1	4%
Child behavior questions	1	4%
<b>Economic Challenges</b>		
Neighborhood violence	8	31%
Public transportation	8	31%
Events in the city (non-child, seasonal)	6	23%
Affordable places to visit in the city	5	19%
Affordable summer programs for children	1	4%
<b>Immigration</b>		
Homeland	8	31%
ESL/Spanish classes	7	27%
Immigration and the law	3	12%
Lack of family/child care concerns	1	4%
Religion as support	1	4%
<b>Personal Well-being</b>		
Self care per se (e.g., doctor visits)	8	31%
Depression	6	23%
Finances	6	23%
Relationships with spouse	5	19%
Adult (non-spousal) relationships and Responsibilities	2	8%
Sleep deprivation	1	4%
Professional goals for self	1	4%