



2023 Program Evaluation

Introduction

This report describes the qualitative and quantitative outcomes of Chances for Children’s 2023 clinical program for families with children pre-natal to age five. [Chances for Children](#) (CFC) uses multiple methods to determine the outcomes of our programs including observational tools, pre- and post-intervention coding of video interaction by external coders, interviews, self-evaluations, and parent questionnaires. Together these give us a robust picture of our service efficacy. ***In 2023, we continued to achieve positive results within multiple methods of measurement.***

Multiple factors impact a child’s developing brain including biology, environment, and culture; a reliable caregiving system of secure relationships is essential for protection, adaptation, and resilience. Nurturing and preserving these relationships within families is a goal of our work. Understanding that different families have different needs, we design our interventions accordingly. This does not fit neatly into measurement instruments; nevertheless, by considering different aspects of the whole of what builds healthy relationships, we can capture aspects of nearly all the families we serve. As Jack Shonkoff, pediatrician and director of the Center on the Developing Child at Harvard, says, “we are still learning what works and for whom”.¹

The Bronx: A Snapshot

Since Chances for Children expanded services from within high schools out into the community in 2008, we have served the Bronx, a dramatically under-resourced community. Data from the Citizens’ Committee for Children of New York (CCC) provides a picture of risk to child well-being across 59 community districts in New York City (NYC). Seven of the highest risk communities in NYC are in the Bronx in neighborhoods in which Chances for Children provides services.

Did You Know?

- The Bronx ranks first among the boroughs in child poverty: 63,023 children live 200% under the Federal Poverty Level according to the Citizens’ Committee for Children in NY.²
- Ranking the highest of all NYC boroughs, 39% of adults in the Bronx live with food insecurity.³

¹ <https://developingchild.harvard.edu/resources/2020-national-prenatal-to-3-research-to-policy-summit/>

² CCC, Citizens’ Committee for Children of New York report, October, 2023, <https://cccnyc.org/data-publications/from-birth-to-age-12-child-care-and-out-of-school-care/>

³ https://www.health.ny.gov/press/releases/2024/2024-01-03_food_insecurity.htm

- Young children from birth to age 4 make up the largest group facing eviction: though children make up only 9% of all renters, they make up 12% of all facing eviction. Children under 5 make up the largest group by age of those whose households have had an eviction filed against them.⁴
- Families in the Bronx pay up to 63% of their annual income on childcare or out-of-school care, which is the highest cost burden in the city.⁵
- In 2022, the serious crime rate in the Bronx was 18.8 serious crimes per 1,000 residents compared to 14.2 serious crimes per 1,000 residents citywide.⁶

Did You Know?

- *Infants and toddlers are the age group most likely to suffer abuse and neglect.* There are 101,344 children under age 5 living in the Bronx, according to the National ZERO TO THREE’s *State of Babies Yearbook: 2023: NY State*.⁷
- It is no surprise that the Bronx ranks first among the boroughs in foster care placements.⁸
- More than 1,400 childcare centers closed in NYC since 2015. The “broken funding model” resulted in \$460 million in unpaid invoices from 2022.⁹ One of the largest programs to close was Sheltering Arms, a collaborating agency.

Who We Are: Our Team

Leadership and Administration

Chances for Children is led by Co-Executive Directors Silvia Juarez-Marazzo and Lillian Rountree. Co-Executive Director Lillian Rountree leads the administrative team which builds and maintains the organization’s infrastructure, secures funding, and solidly scaffolds our services to families and community partners.

Clinical Team

Our clinical team, led by Co-Executive Director Clinical Silvia Juarez-Marazzo, consists of seven therapists (including Silvia), five of whom are Spanish speaking, and all of whom are Masters level clinicians with expertise and experience in infant mental health (IMH). All therapists receive at least two hours of clinical and reflective supervision per week and participate in a weekly academic/case study seminar and a monthly meeting of the whole staff. We anticipate hiring two additional therapists in the coming year.

What We Do: Program Overview

Parent-Child Dyadic Therapy Program

The parent-child dyadic therapy that we provide is relationally based and trauma focused. It aims to strengthen and solidify the bond between the parent and their infant or very young child and to expand and improve parenting skills, including the ability to anticipate and appropriately respond to

⁴ CCC, Citizens’ Committee for Children of New York report, October 2023, <https://cccnewyork.org/data-publications/from-birth-to-age-12-child-care-and-out-of-school-care/>

⁵ibid

⁶ <https://furmancenter.org/neighborhoods/view/the-bronx>

⁷ <https://stateofbabies.org/state/new-york/>

⁸ <https://data.cccnewyork.org/data/map/27/foster-care-placements#27/a/3/47/127/a/a>

⁹ <https://cccnewyork.org/press-and-media/city-council-caucus-proposes-solutions-to-address-early-childhood-care-crisis-in-nyc/>

developmental changes in the child over time. Using evidence-based, best-model practices in the field of infant mental health, we work both preventively and remedially to interrupt the intergenerational transmission of ruptured attachments, environmental and familial trauma, as well as to *prevent* psychological problems early in the life of the child and family before disruption has occurred.

The Parent-Child Dyadic Therapy Program consists of three tiers: consultation, dyadic therapy, and severe trauma-focused therapy. In 2023, we continued to offer services using the hybrid model created during the pandemic so that some families are seen in person and others, who cannot come to our Family Center, are seen via a secure, HIPPA-compliant Zoom platform.

Consultation: Not every family needs full dyadic intervention. Consultation offers a short-term problem-solving arena, where parents receive specialized infant mental health reflective guidance that can help them decide what kind of service best fits their needs. It concludes with recommendations for the family and referrals to other professionals when needed.

Dyadic Therapy: Distinct from parenting programs that do not include the child, our Parent-Child Dyadic Therapy Program is a strengths-based, dyadic model that prioritizes the relationship between parent (or caregiver) and the child. Repeated experiences with parents and children, in which relationships are co-created during moment-to-moment interactions, continue to highlight for us the importance of relationship building as an essential vehicle for long-term change.

Dyadic sessions do not follow a prescribed routine since different families have different needs at different times. Sessions may include the parent and child on screen or in-person, the parent alone on screen or by phone, and in some cases occasionally involving a third party (father, grandmother, or sibling). Sessions may include video recording and video feedback, discussion of parental history that is impacting the parent-child relationship, supporting difficult decisions that a parent is making, processing grief and loss, problem solving, reflective developmental guidance, and encouraging moments of joyful dyadic interaction. Throughout all sessions, behaviors are understood as communications and the perspectives of both parent and child are explored within the cultural context of each family.

Severe Trauma-Focused Therapy: This tier of intervention was created in 2018 in response to an alarming influx of referrals for children who had suffered severe, acute trauma. Severe trauma-focused therapy requires a level of expertise different from the usual dyadic intervention and requires significantly more immediate family support, management of complex systems outside the therapy room, along with the necessity for case conferencing. To address this need, we created a severe trauma-focused therapy tier that provides: individual sessions with parents and collateral family members, parent-child dyadic therapy sessions, case conferencing, and advocacy with lawyers, other therapists, and child protection workers. This intervention continues until there is a resolution of symptoms in the child and a return to a typical developmental trajectory.

Group Program:

The purpose of the Group Program is to reduce isolation among parents with young children, to give families a safe place to be together, and to allow children to see and “play” with other children. These needs were particularly salient during the pandemic, and telehealth groups continue to be appreciated by families who are just now contemplating being in-person. These groups are held in English and Spanish by bilingual therapists. Evaluation of this program is predominantly qualitative and descriptive with quantitative data from our Exit Survey (described below; results reported below).

Program Overview

DYADIC Program

GROUP Program

Consultation

- Parent meets with infant mental health (IMH) therapist
- Up to 5 sessions
- Recommendations are offered
- Referrals to other professionals are made if indicated

Goals:

Support parents responding to typical developmental challenges in children; Expand parental developmental understanding; Support parents navigating life transitions

Growing Together: 3 months - 3 years

- Parent-child dyads meet with 2 infant mental health (IMH) group facilitators
- 4-8 parent-child dyads
- 1 hour weekly
- 8-10 sessions

Goals:

Reduce isolation; Give families a safe place to be together; Allow children to see and "play" with other children

Parent-Child Dyadic Therapy

- Parent and child meet with an IMH therapist
- 1 hour weekly
- 15 sessions, renewable
- Parents are screened for depression
- Children are screened for developmental delays
- Referrals to other providers are made if indicated

Goals:

Strengthen the child-parent bond; Expand the parent's reflective capacity; Increase the parent's developmental understanding; Increase parent-child positive interactions

Pregnant Mothers: Pregnancy-3months

- Pregnant women and mothers with newborns meet with IMH therapist
- 4-9 participants
- 90 minutes weekly
- 6-8 sessions

Goals:

Provide emotional support and information to pregnant mothers and those with infants up to three months old

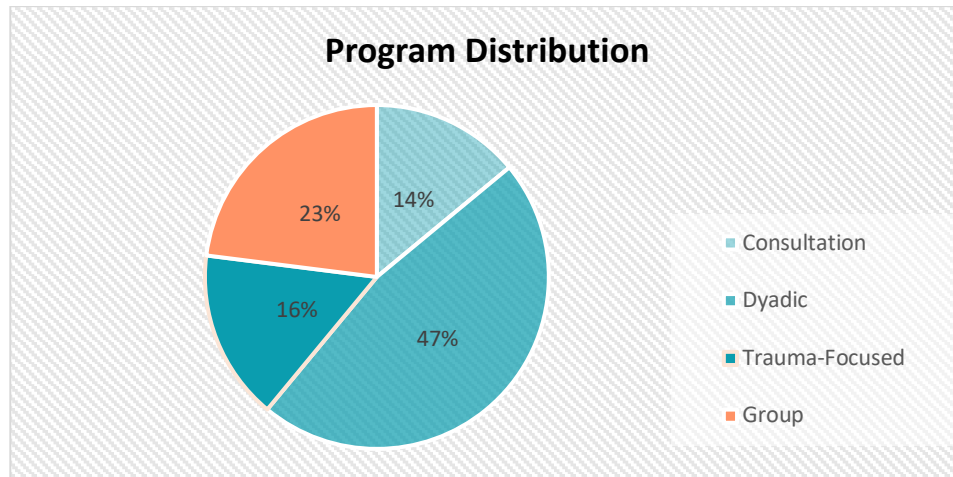
Severe Trauma-Focused Therapy

- Parent and child meet with IMH trauma therapist
- Therapist meets with family members, collateral agencies, and courts
- Length of treatment is dependent on resolution of symptoms

Goals:

Repair the impact of the trauma on the child's social-emotional and overall development; Strengthen the parent's capacity to keep the child safe and protected; Help build a new relationship with a parent if a rupture has occurred in the primary parent relationship

Program and Demographic Information



This year, 184 interventions were provided to 170 unique families, and some families participated in multiple services. The Parent-Child Dyadic Therapy Program (consultation, dyadic, and severe trauma-focused) comprised 77% of the interventions provided to families. Chances for Children received 268 referrals and delivered 1848 sessions (dyadic and group) with an attendance rate of 75%.

Case Overview:

| | Dyadic | Group | Total |
|----------------------------|------------|-----------|------------|
| Assigned (not yet opened) | 2 | 1 | 3 |
| Cases completed | 52 | 26 | 78 |
| Cases ongoing (open) | 42 | 10 | 52 |
| Prematurely discharged | 17 | 1 | 18 |
| Dropped out (< 5 sessions) | 30 | 2 | 32 |
| Total | 144 | 40 | 184 |
| Never began services* | 39 | 5 | 44 |

*44 families were referred and assigned but never began services.

Sessions: Includes both dyadic and group programs.

| | 2022 | 2023 |
|--------------------|-----------------------|-----------------------|
| Sessions scheduled | 2568 | 2452 |
| Sessions attended | 2047 (80% attendance) | 1848 (75% attendance) |

Referrals:

| | 2022 | 2023 |
|------------------------------------|------|------|
| Referrals received | 217 | 268 |
| Referrals declined or referred out | 62 | 80 |

Demographics for Assigned Cases: Includes participants in dyadic and group programs.

| Child Gender (175*) | Yes | % |
|----------------------------|------------|----------|
| Female | 82 | 47 |
| Male | 93 | 53 |

* The number in parenthesis indicates the number of responses available for the item.

| Parent Race (146*) | Yes | % |
|------------------------------------------------|------------|----------|
| American Indian or Alaska Native | 7 | 5 |
| Asian, Native Hawaiian, Other Pacific Islander | 3 | 2 |
| Black or African American | 28 | 19 |
| White or Caucasian | 14 | 10 |
| Mixed Race | 29 | 20 |
| Other | 43 | 29 |
| Unable to Obtain | 20 | 14 |
| Latino (still identified as Latino) | 2 | 1 |

*The number in parenthesis indicates the number of responses available for the item.

| Parent Ethnicity (150*) | Yes | % |
|--------------------------------|------------|----------|
| Latino | 117 | 78 |
| Non-Latino | 26 | 17 |
| Other | 7 | 5 |
| Unable to Obtain | 0 | 0 |

*The number in parenthesis indicates the number of responses available for the item.

| Other Information About Parents | Yes⁺ | % |
|----------------------------------------|------------------------|----------|
| Single Parent (161*) | 84 | 52 |
| Parent Working (147*) | 59 | 40 |
| Parent in School (147*) | 12 | 8 |
| Parent Working and In School (147*) | 9 | 6 |
| Parent in Neither (147*) | 67 | 46 |
| ACS Involved (129*) | 21 | 16 |
| Foster Care (83*) (Dyadic Only) | 6 | 7 |
| History of Domestic Violence (161*) | 58 | 36 |
| History of Trauma (148*) | 93 | 63 |
| History of Mental Illness (149*) | 34 | 23 |
| Current Depression (134*) | 35 | 26 |
| Child Delay/Referred Out (175*) | 39 | 22 |

* The number in parenthesis indicates the number of responses available for the item.

⁺ Yes = number with characteristic. Ex. 84 of 161 were single parents.

Evaluation of the Parent-Child Dyadic Therapy Program

To evaluate our clinical outcomes, Chances for Children uses instruments that measure the following:

- Parent behavior, child behavior, and dyadic mutuality: *Baby Books 2 (BB2)*¹⁰, *Clinical Rating Scale (CRS)*
- Parental capacity to think reflectively about their children: *the Parental Reflective Functioning Questionnaire (PRFQ)*¹¹
- A constellation of parental behaviors that have been correlated with long term negative consequences for child development in western societies: *Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE-BRIEF)*¹²

Two other measures are employed to assess whether there is a need for referral for additional resources:

- *LookSee Checklist*¹³: a developmental screening tool for children from birth to age five that indicates whether there is need for referral to additional services, such as Early Intervention
- *Center for Epidemiological Studies Depression Scale (CES-D)*¹⁴: screens for parental depression

Finally, an *Exit Survey* is externally administered at the end of the program to determine client satisfaction.

With the exception of the Clinical Rating Scale and Exit survey, all instruments are well validated measures widely used in the field of Infant Mental Health. The CRS was designed by Chances for Children during the COVID-19 pandemic as a way of measuring progress without having to use video and has proven to be an extremely useful clinical tool. All instruments are administered in English and Spanish. What follows is a description of each instrument with the outcomes of pre/post intervention.

Baby Books 2 (BB2): The Baby Books 2 coding instrument contains coding schemes for parents and children in free play episodes, designed to meet different developmental levels of children as they age. For the parent, it assesses *Sensitivity, Positive Regard, Intrusiveness, Negative Affect, Stimulation of Development, and Use of language*. For the child, it assesses *Positive Affect, Negative Affect, Sustained Attention, Responsivity, and Use of Language*. For the dyad, it assesses *Mutuality of Interaction*. Videos are coded by independent researchers not affiliated with Chances for Children who are blind to the time of recording (pre- or post-intervention) and information about the parent-child dyad.

¹⁰ BB2 Cabrera NJ, Reich S, & Kuhns C (2017, April). *Baby Books 2: A randomized control trial (RCT) to test the effects of a book intervention for low-income mothers and fathers*. Symposium conducted at the biennial meeting of the Society for Research in Child Development, Austin, TX.

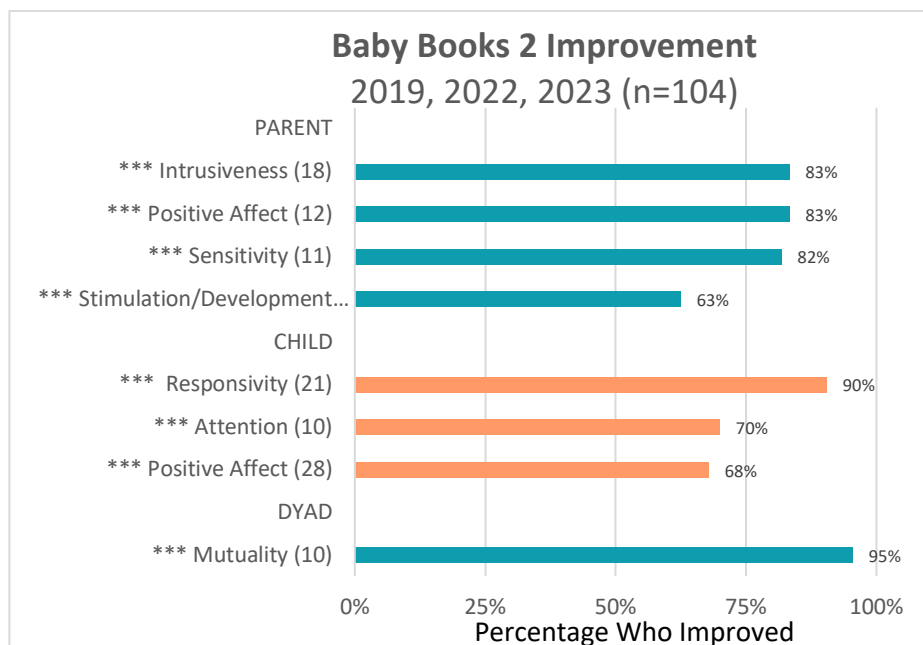
¹¹ Luyten P, Mayes LC, Nijssens L, Fonagy P. The parental reflective functioning questionnaire: Development and preliminary validation. *PLOS ONE*. 2017;12(5):e0176218. doi: 10.1371/journal.pone.0176218

¹² Cooke JE, Eirich R, Racine N, Lyons-Ruth K, & Madigan S. Validation of the AMBIANCE-brief: An observational screening instrument for disrupted caregiving. *Infant Ment Health J*. 2020; 41:299-312. <https://doi.org/10.1002/imhj.21851>

¹³ <https://www.halton.ca/For-Residents/Children-and-Parenting/Parenting-toddlers-preschoolers/Tracking-Your-Child%E2%80%99s-Development-Nipissing-Dist>

¹⁴ Radloff, L. S. (1977). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurements*, 1, 385-401.

Below we present our combined findings from Baby Books 2 for the three years for which we have outcomes: 2019, 2022, and 2023. (We were unable to record and code videos during the COVID-19 pandemic of 2020-2021). This gives us a larger sample and greater statistical power.



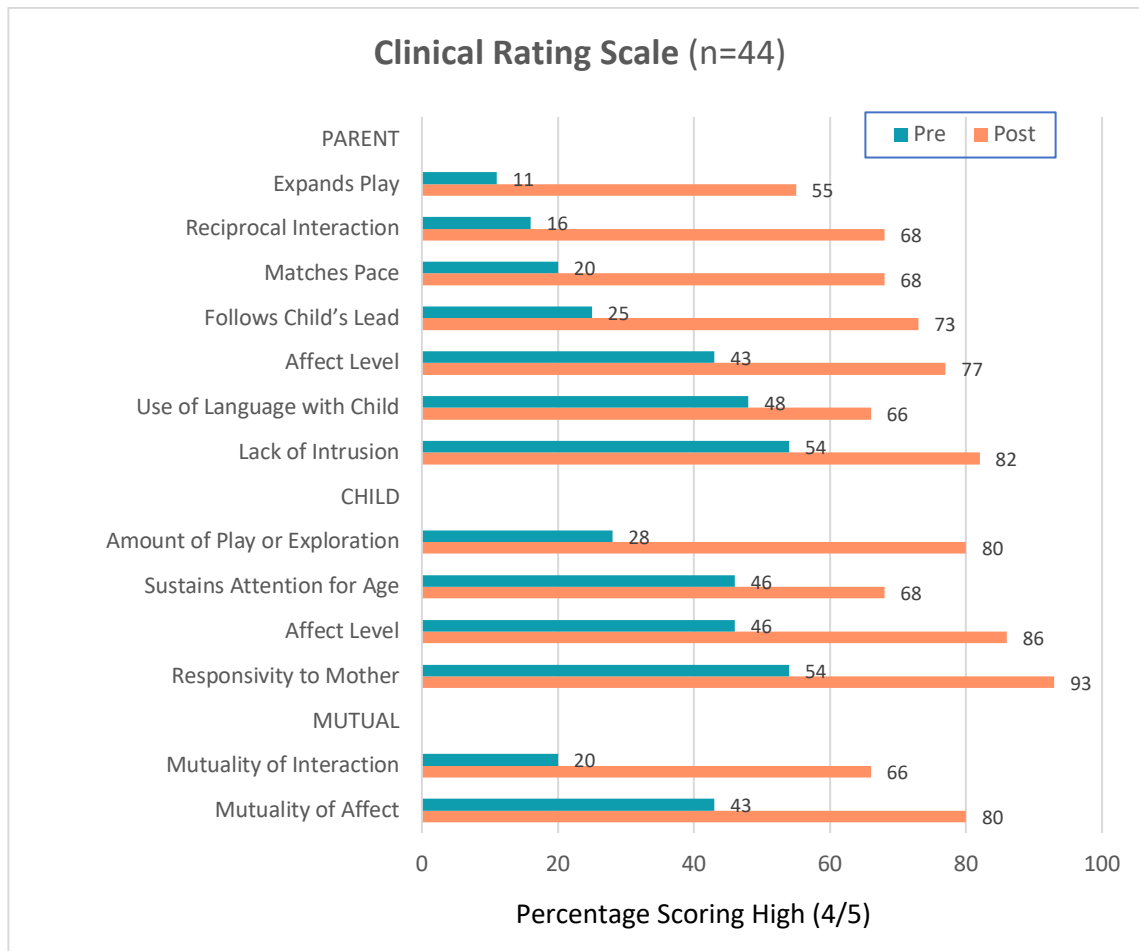
Bar Graph Explanation: We conducted statistical tests to determine whether a behavior had improved after participation in our intervention. The combined Baby Books 2 data from 2019, 2022, and 2023 were used (n=104). In those individuals who showed a *poor* level of a particular behavior before participation and thus needed to improve that behavior, we tested whether their score went from *poor* to *good* using a one-sample binomial test. **Such parents and children showed improvement for all measures.**

For Baby Books 2, individual items are coded 1-5 or 1-7. Those beyond the midpoint on this spectrum were defined as *poor*. For example, for *Parental Sensitivity*, codes of 1 or 2 were defined as *poor* of the 1-5 possible. Of the 104 dyads coded, the number showing *poor* scores at baseline in each area varied.

In the bar chart above, the number who had scored *poor* is indicated after each item in parentheses. The length of each bar represents the percentage of them who had improved to *good* after the intervention. For example, there were 12 parents whose *Positive Affect* was *poor*. Of these parents, 83% (10/12) showed improvement such that *Positive Affect* was *good*. This improvement was statistically significant, as shown by the three asterisks. **Improvements in all areas were statistically significant.** Items for which small numbers of individuals exhibited *poor* behavior for these items were not included. These include *Parental Negative Affect (1) and Detachment (3)*, *Child Negative Affect (3) and Non-Compliance (4)*, and *Dyadic Conflict (2)*.

The Clinical Rating Scale (CRS): The CRS consists of three sets of questions designed to rate the parent-child interaction: parent behavior, child behavior, and dyadic interaction by the therapist. This gives us three domains of information about each parent-child interaction, for example, the parent's *Use of Language with Child*. The scale is rated as soon as possible after the first observed therapy session with the dyad, again in the middle of the intervention, and finally at the end. Because this is a clinical tool, it can also be used by therapists at any time during the intervention to monitor progress and assist in

treatment planning. It can also be used to code video recordings. Below we report the outcomes for the 2023 cohort of dyadic cases (44) for which we had pre-post intervention video recordings.



Bar Graph Explanation: The horizontal bar graph above illustrates the levels of need and levels of improvement after interventions. Blue bars indicate the percentage of parents rated *good* (4/5) at the first scoring. The orange bars indicate percentages of parents rated *good* after intervention. This is across the full sample (n=44) across all measures in the Clinical Rating Scale. All measures are scored 1-5. Numbers given for each measure represent the percentage of individuals who were rated as being at a score of 4/5 [*high/very high*]. Rates are given for both the pre- and post-intervention assessments recorded. For example, for *Parent Reciprocal Interaction*, at the first assessment, only 16% rated *high/very high*. At the final telehealth assessment recorded, 68% showed *high/very high*. (For *Parental Intrusion* we assessed what percentage occasionally or never intruded.) **All CRS items show a statistically significant increase, testing across all 5 levels of each item.**

Correlation of Baby Books (BB2) and Clinical Rating Scale (CRS): Last year we began considering whether the CRS, created during the pandemic by Chances for Children, would correlate appropriately with items in the BB2, thereby validating the use of the CRS as an instrument. (That is, does the CRS measure validly reflect the intended construct?) To understand this, we considered the relationship between items on the CRS and items on BB2. Correlations were conducted between all CRS items and all BB2 items. We found moderate correlation between the two scales. That is, items that should correlate positively between the two scales do so, those that should negatively correlate do so, and where

correlation should fail between items, they fail to be correlated. For example, parents who are rated as having higher levels of *Reciprocal Interaction* in the CRS also show higher levels of *Sensitivity, Stimulation of Development* and *Positive Affect* in BB2. Furthermore, those parents showing higher levels of *Reciprocal Interaction* show lowered levels on BB2 of *Intrusion* and *Detachment*. These relationships support the use of the CRS as an instrument to measure our client's improvement in parental behavior, child behavior, and parent-child interactions. (All statistical analyses are available upon request.)

Parent Reflective Functioning Questionnaire (PRFQ): This self-report measure is completed with the therapist and consists of 18 statements that parents rate on a scale of 1-5 from *strongly agree* to *strongly disagree*. It assesses the capacity of a parent to “see the world through their baby’s eyes” and understand that behavior (including their own and other adults’) is influenced by mental states (wishes, beliefs, thoughts) and contributes to healthy relationships. Certain questions alert us to a tendency toward negative attributions about the child (ex. “*My child cries around strangers to embarrass me*”) and others to a rigidity of thinking (“*I always know why my child acts the way he or she does*”).

This questionnaire divides parental reflective functioning into three components: first, parents vary in their levels of *interest and curiosity* regarding their children’s mental states; second, parents also vary in their *certainty regarding their understanding of the child’s mental states*, and third, many parents have not developed the capacity to mentalize about their child’s states of mind, called *Pre-Mentalizing or Non-Mentalizing*. We would expect the parent’s *Pre-Mentalizing* scores to decrease, their interest and curiosity scores to increase, and the certainty of mental states to be midrange.

Chances for Children has collected PRFQ data since 2019; however, during the pandemic years (2020 and 2021) we were unable to collect post intervention data. Here we present our combined results across the years with both pre- and post-intervention data. (A combined year assessment provides greater numbers and greater statistical power.)

| PRFQ 2019, 2022, 2023 (n=101) | | | | | |
|----------------------------------|---------------|----------------|-------------|---------|-------------|
| | Pre M (SE) | Post M (SE) | t(df) | p-value | Effect Size |
| Pre-Mentalizing | 2.51 (.14) | 1.61 (.08) | -7.95 (100) | <.001 | -.79 |
| Certainty about Mental States | 4.15 (.13) | 4.17 (.14) | .19 (100) | .426 | .02 |
| Interest & Curiosity | 5.72 (.10) | 6.28 (.08) | 5.95 (101) | <.001 | .59 |

A paired t-test was conducted to determine whether scores on each PRFQ scale changed after intervention. On average, parents showed lower levels of *Pre-Mentalizing* after intervention, dropping from a mean of 2.51 (SE=.14) to a mean of 1.61 (se=.08), $t(101)=-7.95$, $p<.001$. This level of change is considered a large effect, Cohen’s $d = -.79$. Parents’ levels of *Interest & Curiosity* increased after intervention, changing from 5.72 (SE=.10) to a mean of 6.28 (SE=.08), $t(101)=5.95$. The effect is considered moderate, Cohen’s $d=.59$. The mean level of *Certainty about Mental States* did not change after intervention. ***In summary, the strong drop in Pre-Mentalizing and increase in Interest & Curiosity show a powerful and consistent benefit for parents who participate in our intervention.***

AMBIANCE-brief: The AMBIANCE-brief measures disruptive parent behaviors which potentially lead to disorganized attachment patterns that have been linked to diverse forms of psychopathology later in life for the child, including borderline personality disorder (Lyons- Ruth).¹⁵ According to attachment theory, infants need caregiving that provides a secure base that can consistently modulate infant arousal; this enables the child to form a consistent strategy for using the parent as a source of comfort when under stress. The different behaviors that together comprise a pattern of insufficient caregiver protection are captured in the AMBIANCE.

Coding: Videos were coded pre- and post-intervention for level of disrupted parent behaviors. Videos are coded on 5 dimensions of behavior organized around profiles of helpless/withdrawn behaviors and intrusive/self-referential behaviors. After coding on all dimensions, coders assign a single level of disrupted communication to each dyad. Higher scores indicate more disrupted parenting on a scale from 1-7; with scores 3 and below indicating *Non-Disrupted Caregiving*, 5-7 degrees *Disrupted Parenting*, and 4 indicating *Non-Optimal Style but not Disrupted Behavior*.

Results: In 2023, we coded 64 videos (32 parent-child dyads). Of those 32 dyads, 12 (38%) scored in the disrupted categories at first coding (T1), pre-intervention. At the second coding post intervention (T2), only 2 dyads remained in the disrupted categories. Ten dyads no longer displayed disrupted behaviors. Further examination of the two dyads demonstrating disruptive behaviors showed that one dyad who had been mandated lost interest once her child was returned to her from fostercare, and the other family was dealing with substantial life transitions that interfered with our work together. In summary, all but two parents were ***able to alter their caregiving sufficiently to meet criteria for non- disrupted caregiving.***

The LookSee Checklist: Formerly the Nipissing District Developmental Scale (NDDS), this is a developmental screening tool for children from birth to age five and indicates whether there is need for referral to additional services, such as Early Intervention. This is completed close to the start of intervention and administered by therapists in English and Spanish. ***This year 39 children were referred for Early Intervention screening and services.***

Exit Survey Results: Both dyadic and group participants are surveyed at the end of their intervention (see page 13 for results).

Evaluation of the Group Program

Growing Together Group

Groups were held via Zoom in three cycles, each consisting of two groups. Groups consisted of 4-7 dyads, (10 to 14 individuals) per session. Like the families in our other program, group families were largely Latino, with 2-7 people living in the home. The biggest difference noted between group and dyadic program participants was that group parents reported fewer worries about their children; however, nearly half worried about having enough to pay rent or buy food. Many reported a deep sense of isolation, with nearly half reporting serious COVID impacts and death among family members.

¹⁵ Lyons-Ruth, K. (2008) Contributions of the mother-infant relationship to dissociative, borderline and conduct symptoms in young adulthood. *Infant Mental Health Journal*, vol 29:3. Wiley. <https://doi.org/10.1002/imhj.20173>

Growing Together Groups were created as a means of easing isolation among young families who felt they did not have a safe environment outside of their homes to meet with other families and have their children socialize with other children. The groups are carefully structured to provide community, joyful activities, information about child development, and routine. All groups are bilingual (English and Spanish) and ranged from 4 to 7 dyads with children of mixed ages from 6 months to 4 years.

Each group was conducted by two therapist facilitators and followed a consistent routine: 1) welcome song, 2) a parent-child check-in, 3) play activities (singing, art project, dancing, crafts), 4) story time, 5) reflective discussion, and 6) a good-bye song. Examples of themes explored in the reflective discussion include: the sharing of cultures, supporting the development of baby's confidence, developmental challenges of different ages, and the importance of connection through play.

Since the COVID-19 pandemic, our Growing Together Groups have been conducted via Zoom and have been evaluated through exit surveys and parent feedback. We are looking forward to reinstating our in-person groups after moving to our new space in 2024! We will also be piloting two measurement instruments at that time.

Perhaps the parents' own words best capture the importance of these groups in parents' lives:

"...I always felt supported and encouraged in my journey of motherhood. I appreciated sharing my experience and learning from others' experiences. It gave us a sense of relief and a sense of hope to keep going and strengthening the foundation in our journey of motherhood."

"We appreciated the company, time, patience, and lessons we got from the group and therapists. In every situation, you had a word of support for us. The time we've been in group seems like not a lot but what we got out of it was a lot."

"For us, mother and baby, the experience was gratifying, being in the group was like going on a roller coaster, each session full of great surprises and activities. The group helped me understand that to support the baby it is necessary to give her space and time and teach her to understand her feelings and the importance of giving them examples for adult life. We were a family of moms and I hope other moms and babies really enjoy the group."

"I learned new things. I let go of a belief. Before I thought only other Mexican moms could understand me, but now I see even if we are of different backgrounds, we have the same rhythm, and I learned from every mom that sometimes you feel like you're going through something on your own. You question "Why is this happening to me?" But then you realize you're not the only one...(you) always gave us the crucial clue or wisdom to help explain, and in those moments, it was what I needed to hear and brought me calm."

Pregnant Mothers Group

There is growing evidence that prenatal stress, especially if it is chronic, has serious adverse effects on the growing fetus. During the perinatal period, the baby's immune and metabolic systems are developing setting the course for future health; both systems can be altered by chronic environmental stress. The Center for the Developing Child at Harvard has challenged early childhood providers to "make science actionable". As explained by Jack Shonkoff, "science is showing us that it is not the activation of stress hormones early in life that undermines the healthy development of biological systems, but the *chronicity of the activation* of stress hormones that often results in decades of lifelong disease."¹⁶ In 2021, Chances for Children began Pregnant Mothers Groups to reduce prenatal stress. These groups offer mothers a predictable routine consisting of a 1) a check-in "being with baby this week of your pregnancy," 2) a playtime activity for babies in utero or newborn, 3) a body-based affect regulation activity, 4) topics for reflection (cultural expectations about motherhood...), and 5) a closing lullaby.

Though we were unable to continue the program because of a change in priorities of the collaborating agency, we have already reinstated these groups within another partner organization for the year ahead. Additionally, in the coming year, we will begin to pilot some new measures to assess the effect of these groups. In addition to groups, we have begun working more actively with pregnant mothers individually and are seeking new referral sources for this population.

An Additional Group to Meet an Unexpected Need

Chances for Children strives to respond to the sudden needs of our partner organizations. This year four in-person parent-baby group sessions were held on-site at a collaborating agency to help parents process the loss of a program on which they depended. Nine parent-baby dyads participated in these group sessions. One mother told us:

"¡Qué emoción re-encontrarnos con las mamás, los niños y los bebés y volver a jugar, platicar y aprender juntas. Necesitamos este espacio seguro!" (I felt such emotion meeting the moms, the children, and the babies again, playing and learning together again. We needed this safe space!)

Exit Survey Results

At the end of intervention, an anonymous Exit Survey is conducted by phone by an external evaluator. There were 41 exit surveys conducted this year with 28 dyadic and 13 group participants (the external evaluator attempts to reach each parent three times; however, not all parents respond). Parents score statements on a Likert scale from 1-4 (1: *strongly disagree*; 2: *disagree*; 3: *agree*; 4: *strongly agree*, with 5 as *not applicable*.)

100% of parents *strongly agreed* or *agreed* that:

- *Interactions with my CFC consultant have been sources of support.*
- *The CFC consultant has offered me strategies and activities that help me play with my child and support her/his development.*
- *It is easier for me to find words to explain things to my child.*
- *I look forward to speaking with my CFC consultant.*

¹⁶ <https://developingchild.harvard.edu/resources/2020-national-prenatal-to-3-research-to-policy-summit/>

- *I would recommend a CFC consultation to other families looking for services.*

All parents, except one, reported that they *strongly agreed* or *agreed* that:

- *Sessions with CFC helped me begin to resolve the problem that brought me to services.*

At the end of the survey, participants are asked if they would like to share something they remembered about the program. Here are several comments:

“My son went from super shy and clingy to excited to go in. He would grab the therapist’s hand and wanted to play, that was the biggest change that I saw. There was a lot of progress made. He was more curious, open to interacting, more eye contact. It was like day and night from the first session to the last. I am so thankful to Chances for Children and my therapist.”

“I have to listen to my daughter. If I notice that she is frustrated, I need to try to talk to her and say, ‘I see you are frustrated.’ I need to try to understand her.”

“My therapist was very good and supportive. She helped me in how to respond to my children’s reactions. I was desperate and my therapist showed me how I could react “better” and how I could help my children.”

“When we worked with our therapist, she helped me not only to understand my child, but she helped me understand myself and how my emotions help me to work and keep a close and relaxed connection with my child. The therapists in this program know adult and child psychology and understand the adult and the child to help them speak the same language. I am so grateful to my therapist and will remember her for the rest of my life.”

Supporting Collaborating Partners: Training & Consultation

As part of Chances for Children’s commitment to infant mental health, we are available to offer support to our collaborating agencies through workshops for their staff and families. The following is a list of this year’s workshops, consultations, and their attendance, as well as presentations that were requested.

| Program | # of Sessions | Attendance |
|---------------------------------------------|---------------|------------|
| Workshops for Teachers | 12 | 251 |
| Presentations to Lawyers and Judges | 1 | 65 |
| Virtual Workshops for Parents | 2 | 24 |
| Virtual Open House Events for Professionals | 1 | 7 |
| In-Person Socialization Groups for Parents | 8 | 302 |
| Interactive Orientations for Parents | 2 | 130 |
| Presentations for Professionals | 24 | 100+ |

Reflective Consultation and Trainings: Weekly, we provided 4-5 hours of reflective consultation and monthly specifically designed trainings for the Cardinal McCloskey Community Services' Early Head Start Home Based Team, from January until July 2023.

Conferences and Special Presentations:

- 4th Annual Art of Play and Wonderment Conference, (panel, workshop, and closing remarks), June.
- Blue Ridge Lab Fellowship, Interactive Talk with Blue Ridge Lab fellows, June.
- World Association for Infant Mental Health (WAIMH) Annual Conference, Dublin, Ireland, (presentation), July.
- The Migration Conference, Hamburg, Germany, (presentation), August.
- SBH Pediatrics Grand Rounds, (presentation), December.

Publications: The 22-year Journey of Psychodynamic/Attachment-based Infant Mental Health in Underserved Communities. *Int J Appl Psychoanalytic Studies*. 2023:20: 190-204¹⁷

Looking to the Future

Our plans for 2024 are exciting with the potential for great rewards. Having signed a lease on a larger and more accessible space for our Family Center, we will be able to expand our offerings of both group and dyadic services in person, something parents have been asking for. For families who cannot come in person, we will continue to provide virtual services. We will, of course, continue to provide our services on-site at community partners' programs as well.

In 2024 we will be piloting two new outcome measures for the Growing Together and Pregnant Mothers Groups. In addition, we will revise the Clinical Rating Scale to refine the definition of items and train external evaluators to code videos.

We continue to explore different ways of measuring our outcomes when clients' referring issues are so widely different. For example, a child who struggles with poor attention and hyperactivity will need a different kind of intervention from a child who is traumatized and frozen. Consider these different scenarios: a child reuniting with a parent from foster care, a family whose home was destroyed in fire, a child who has been or is being threatened with expulsion from preschool, a selectively mute child, a family struggling with the death of a parent and spouse, or the effects of mental illness or interpersonal (domestic) violence on parent and child. Each of these scenarios carries a unique complexity requiring individual assessment and its own unique treatment.

Over the years, Chances for Children has considered pre-post intervention recordings that look at the parent-child interaction to be the best measure of success, but what if the presenting problem is not between the child and the parent, but between the child and a poor school environment, or if **both** parent and child are grieving the sudden loss of the other parent? In these cases, the effects and impact of a Chances for Children's intervention may well not be captured in a video recording of the parent-child interaction. The intrinsic diversity of our population and its needs highlights how problematic it is to use

¹⁷ Read-only link to the article:

<https://onlinelibrary.wiley.com/share/author/I4INPCTBJD6HHFJF8C5N?target=10.1002/aps.1809>

“one size fits all” measurement approaches, and so we rely on the capacity of the different measuring instruments to capture the vastly complex achievements of the different families we serve.

Conclusion

After 23 years working with parents and young children, we continue to be amazed by the lessons families teach us. It is the remarkable support of our funders that has allowed us the flexibility to put those lessons into practice, enabling us to continue to produce robust positive results again this year. Our positive feedback from families indicates that, along with strengthening critical nurturing relationships within families, our program may indeed be lessening family stress. This is essential as there is growing evidence that early adversity has lifelong negative effects on mental and physical health (specifically heart disease, diabetes, and depression¹⁸) at great cost to society. Continued support for our work, gives us hope that more children in the Bronx may grow and flourish in their mental and physical health in supportive families where the intergenerational transmission of trauma and hopelessness has been interrupted at the most sensitive time in human development. Thank you.

Pamela and Miriam

Pamela, a young immigrant mother, was referred to Chances for Children by her baby’s pediatrician for parent-child (dyadic) therapy to be conducted on Zoom as Pamela rarely left her home. On the screen Pamela appeared expressionless; she was dressed fully in black, and her baby was nowhere to be seen. She described a husband who worked long hours and was periodically abusive when drunk. Before giving birth to her baby girl, Pamela had delivered Marco, a baby boy with a neural tube defect who died within the first week of life. Within the year Pamela was pregnant again, but when she gave birth to a healthy little girl, she felt only grief and reported seeing only the face of her dead son. Pamela lived wrapped in shame, guilt, and grief. Continually blaming herself for her son’s death, she cared for her daughter in a robotic trance.

In the first video we made together, Pamela is virtually silent. Miriam is in a baby seat on the floor and Mom has placed a baby mirror between the baby and herself. When Miriam sneezes, Mom wipes her face in a perfunctory gesture and straightens the child’s shirt before sitting back and looking at her hands.

Miriam is looking at her mother. She kicks her legs and wiggles her arms; she reaches for a rattle Mom has put in her lap and shakes it, looking to see what Mom will do. She begins to blow bubbles and babble; she does everything she can to rouse her mother and enliven her. She goes quiet and tries again, but Mom’s face doesn’t change even as she continues to hand baby toys. Mom says that she supposes Miriam is a good baby, but that she screams when she puts her down and won’t let anyone else hold her. Miriam seems to need physical contact at all costs and Pamela says it is becoming unbearable. *“So I just leave her alone, but then she clings harder and screams louder, and that’s how it goes.”*

Miriam needed help thinking and talking about Marco so she could grieve fully. She needed to share smashed hopes and dreams, to give voice to her shame and guilt, to find rituals to contain her grieving,

¹⁸ <https://developingchild.harvard.edu/resources/2020-national-prenatal-to-3-research-to-policy-summit/>

and to be accepted in all her moods with all her feelings. We asked ourselves, “Could Pamela find a way to delight in her child without it wiping away Marco and his place in her world? Could she hold both the grief and joy simultaneously without guilt or shame? Could she allow herself and her daughter to go on living, even though she could not keep Marco alive?” During therapy, Pamela created a collage and wrote a letter to Marco. On Marco’s birthday, she carried them with her to the cemetery, tied them to balloons and let them fly into the sky.

During sessions, Pamela was encouraged to observe and reflect on “the baby in the room”, to wonder about her and what she might need from her mother. Dialogue floated back and forth between the ghost of Marco and the living baby, as therapist and mother tried to disentangle one from the other.

Pamela was helped to pretend with Miriam and to find small ways of sharing joy—bubbles, peek-a-boo, puppets, and before long the delighted baby began to reach her distant mother who found herself able to find moments of pleasure to hang on to.

In their final video, Miriam and Pamela are playing on the floor with baby farm animals. Miriam repeatedly hides the baby calf and giggles gleefully when the mommy cow finds her. Miriam could play this game endlessly, but it must only be the baby calf who is found according to Miriam. Pamela nevertheless finds ways of visiting the other animals who must stay sleeping in the barn.