



2022 Program Evaluation

Introduction

This report covers the period of January 1 through December 31, 2022, and describes both qualitative and quantitative data about our clinical program. For the past two years, Chances for Children offered families, with children from prenatal to age five, dyadic and group interventions via telehealth (virtual) using a secure video format. Services are provided in English or Spanish. Beginning in mid-April 2022, as families began to emerge from the pandemic of the prior two years, we initiated a hybrid model of services to families, making it possible for families who were vaccinated to come to our center for in-person dyadic sessions if they so chose. Our group intervention has remained virtual. The COVID-19 pandemic affected families in the Bronx particularly hard, and its aftermath is equally complicated. Once again, we are deeply grateful to be able to design our infant mental health services to meet the needs of Bronx families as we learn what will and won't work for them and how best to meet the new challenges that have arisen.

We have reaffirmed our commitment to our mission: to provide clinical group and dyadic services for families with young children to strengthen understanding, enhance sensitivity, and nurture relationships. Children and their caregivers (mothers, fathers, extended family members or other caregivers referred to below as "parents") participate together in services.

Following a snapshot of the Bronx as it existed in 2022, you will read about one of the most intractable repercussions of the pandemic that we have encountered. We then outline the programs provided by Chances for Children, explain our evaluation tools, provide the clinical outcomes from the past year, and share feedback and stories from the families we served.

Bronx Snapshot

POVERTY

- 24% of people in the Bronx live in poverty which is double the rate in New York state (13.9%), and more than double the rate in the United States overall (12.8%).
- 34% of children under age 18 in the Bronx live in poverty;
<https://censusreporter.org/profiles/05000US36005-bronx-county-ny/>

HEALTH

NYC's poorest neighborhoods, which also have the highest proportion of Black and Latino residents, have [death rates which are 30% higher](#) than those in wealthier neighborhoods. In the South Bronx, the poorest urban congressional district in the country, the population suffers high rates of diabetes, obesity, heart disease, asthma, HIV/AIDS, and infant mortality. <https://institute.org/bronx-health-reach/about/about-health-disparity/>

FOOD INSECURITY

No Kid Hungry made the following projections for 2022: 26% of children in NYC are food insecure while in the Bronx the rate is 36%, higher than any other borough.
<https://state.nokidhungry.org/new-york/wp-content/uploads/sites/16/2022/01/NKH.NYC.PolicyAgenda.2022.pdf>

EMPLOYMENT

In November 2022:

- 5.3% Rate of Unemployment in NYC
- 7.4% Rate of Unemployment in the Bronx
- Unemployment rate in the Bronx is at least 2% higher than every other borough in NYC.
<https://dol.ny.gov/local-area-unemployment-statistics>

COVID-19 LOSSES

- 1 in every 200 children lost a parent to COVID-19 in NYC.
- “The racial disparities in NYC are more pronounced compared to the rest of the country. Across the US, Black children, for example, are two times more likely to lose a parent or caregiver to COVID-19 than white children. Here they are 3.3 times more likely to suffer the same loss.”
<https://www.thecity.nyc/2022/4/20/23033998/1-in-every-200-children-nyc-lost-parent-covid-twice-national-rate>

HOUSING

- “Rising rents are taking up, on average, 4.6% more of a median family income in the Bronx than this time last year”
- Eviction filings have risen particularly in the areas we serve: Morris Heights, Melrose, Van Cortlandt Park, Highbridge, Bathgate, Jerome Park, Belmont, and Bronx Park South.
- The number of children in shelters has risen 32.8%
<https://comptroller.nyc.gov/newsroom/newsletter/new-york-by-the-numbers-monthly-economic-and-fiscal-outlook-no-70-october-11th-2022/>

EDUCATION

For those in many parts of the Bronx, the COVID-19 pandemic was particularly crushing and has left a legacy of broken systems and families facing new challenges. For many parents of three and especially four-year-old children, the past year has been devastating—not to mention for the children themselves. Chances for Children is witnessing epidemic levels of referrals for four-year-old children struggling in school. This is leading to suspensions and expulsions at an alarming rate, leaving parents overwhelmed, embarrassed, and worried about repeated calls from their child's school that interfered with their ability to work and led to concern for their child's well-being.

Two critical issues have emerged as we have tried to understand what is happening:

- **Four-year-old children are entering school having missed two years of social-emotional development.**

Typical social-emotional development occurs gradually with ever increasing exposure to different people of different ages in different environments. Here the child learns what is safe, what is dangerous, what the “rules” of behavior are, and how to manage and identify the big feelings that accompany new experiences with new people in new circumstances. Four-year-old children of 2022 (especially children without siblings) spent critical years of development in COVID-19-isolation with deeply stressed, isolated adults. Coming out of isolation, they entered school in which, because of COVID-19 restrictions still in place, there was no phase-in period that allowed parents to introduce little ones to this new thing called school. Teachers were faced with classes of four-year-old children with no social-emotional group experience and were totally unprepared to teach the necessary skills. Instead, many carried on expecting the four-year-old behavior they had been used to pre-pandemic.

Recently, a mother we work with described going to get evaluation results for her four-year-old who was reportedly displaying unmanageable behavior in the classroom. The child psychologist told her that her child “*had the brain of a two-year-old.*” This extraordinarily insensitive comment was only one description in a sea of negative attributions assigned by school authorities, administration, and teachers vilifying children who are struggling in school, increasing the already staggering numbers of children expelled from preschool and kindergartens, particularly in communities of color. Here we see the reality of the “preschool to prison pipeline” at work.¹

- **Publicly funded early childhood programs cannot keep their classrooms staffed at all, let alone with qualified teachers, which leaves children feeling unmoored.**

During a recent observation of a classroom of three-year-old children, a Chances for Children therapist noted that over the course of two hours, six “teachers” were randomly in charge. There appeared to be no schedule of activities and little structure to contain the children. For very young children having their first experience in school, there must be a consistent adult to rely on to feel safe. This example is sadly only one of several disturbing classroom observations undertaken by our

¹ Children in pre-K are expelled at 3 times the rate of K-12 students, while children in childcare programs are expelled at 13 times the rate of K-12 students. <https://equaljusticesociety.org/wp-content/uploads/2021/09/Breaking-The-Chains-2-The-Preschool-To-Prison-Pipeline-Epidemic-PDF.pdf>

therapists this year. In some cases, we have been able to intervene with the school who welcomed our recommendations; in others our work became to help parents understand their child's behavior as a response to a toxic environment, mitigate punitive parental responses that exacerbated the child's stress, reduce parental shame, and despair, and support the parent to find a different educational setting.

- Young students who are expelled or suspended are as much as 10 times more likely to drop out of high school, experience academic failure and grade retention, hold negative school attitudes, and face incarceration than those who are not.
- Students who are economically disadvantaged were up to 4.5 times more likely to be suspended than non-economically disadvantaged peers in NYS in the 2020-21 school year. <https://thechildrensagenda.org/wp-content/uploads/2022/10/Solutions-Not-Suspensions-Policy-Analysis3.pdf>

Clinical Team

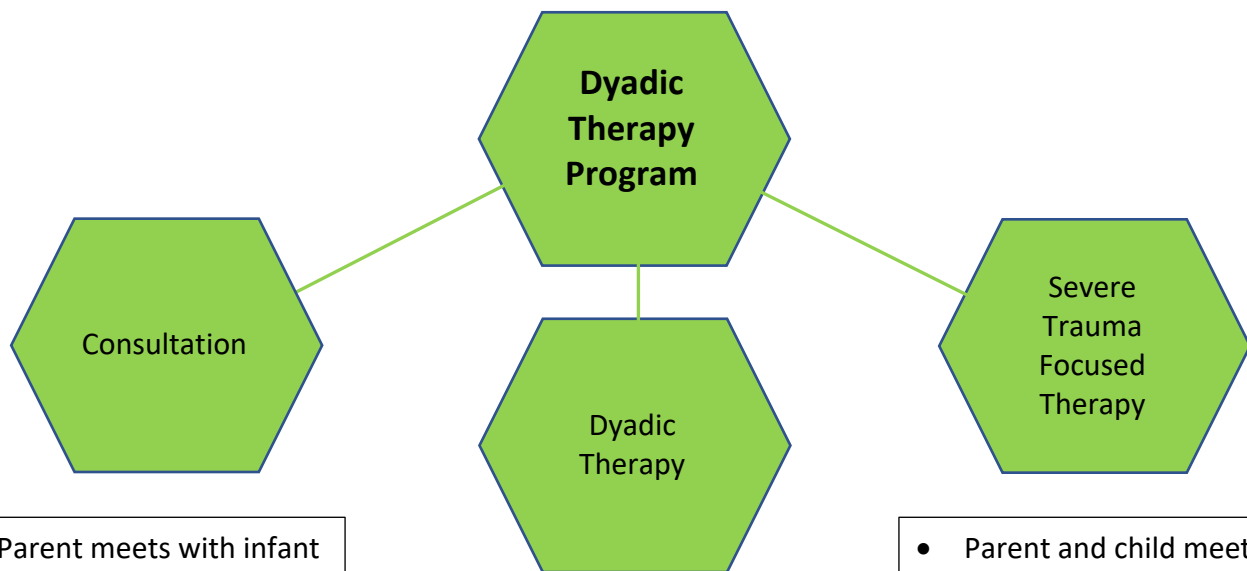
Our clinical team expanded in 2022 and we plan further expansion in 2023. Currently, Chances for Children employs seven therapists (5.6 FTE) with expertise and experience in infant mental health and master's level training, four of whom are bilingual in English and Spanish. Additionally, a second-year intern from the McSilver School of Social Work at NYU will finish her training with Chances for Children in the spring of 2023. We are committed to team support and provide one hour per week individual clinical reflective supervision to both group and dyadic therapists, a weekly clinical team meeting, and a monthly administrative meeting.

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 developmental changes in the infant 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: dyadic therapy, severe trauma focused therapy, and consultation. In 2022, our services were provided primarily via telehealth - the therapist, parent, and child met weekly over Zoom. As pandemic regulations eased, several families who were vaccinated returned in person. This helped us structure the hybrid model that is in place currently.



- Parent meets with infant mental health therapist
- 1 hour weekly for a series of 1-5 sessions
- Recommendations are offered
- Referrals to other providers are made, if indicated

Goals:

1. *Support parents responding to typical developmental challenges in children*
2. *Expand parental developmental understanding*
3. *Support parents navigating life transitions*

- Parent and child meet with infant mental health therapist
- 1 hour weekly for a series of 15 sessions
- This series is renewable
- Parents are screened for depression and children are screened for developmental delays
- Referrals are made if indicated

Goals:

1. *Strengthen the child-parent bond*
2. *Expand the parent's reflective capacity*
3. *Increase the parent's developmental understanding*
4. *Increase the parent-child positive interactions*
5. *Assess for early developmental indicators*
6. *Provide referrals*

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

Goals:

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

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 a third party (father, grandmother, or sibling). Sessions may include video recording and video feedback, discussion of parental history that is impacting present behavior, supporting difficult decisions that a parent is making, processing grief and loss, problem solving, 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:

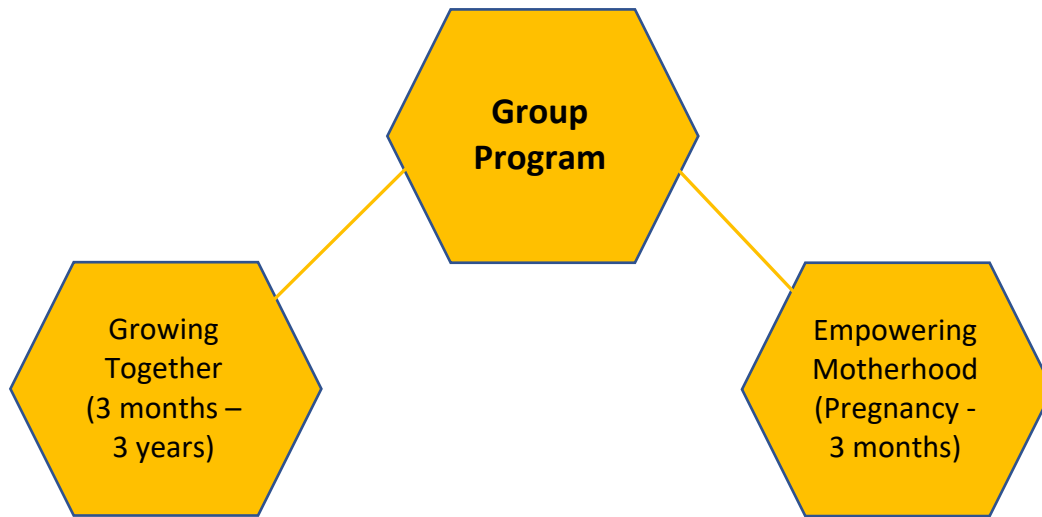
This tier of intervention was created in 2018 in response to an alarming influx of referrals for children who had suffered severe, acute trauma. Severe Trauma Focused Therapy requires a level of expertise different from the usual dyadic intervention and requires significantly more immediate family support, 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, and case conferencing 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.

Consultation:

Not every family needs full dyadic intervention. Consultation offers a short-term problem-solving arena, where parents receive specialized infant mental health 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.

Group Program

In addition, we offer two group programs: one for parents with children from birth to age three to reduce isolation, give families a safe place to be together, and allow children to see and “play” with other children, the second to provide support to pregnant mothers and those with newborns up to three months.



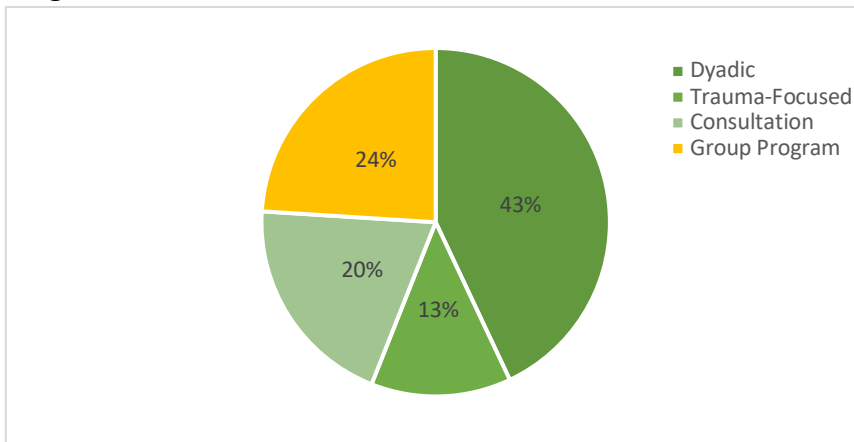
- Parent-child dyads meet together with two infant mental health therapist group facilitators
 - 1 hour weekly for 8-10 sessions
 - Group Size: 4-8 parent-child dyads
- Goals: to reduce isolation, give families a safe place to be together, and allow children to see and “play” with other children.*

- Pregnant mothers and mothers of newborns meet with an infant mental health therapist group facilitator
 - 90 minutes weekly for 6-8 sessions
 - Group Size: 4-9 pregnant mothers
- Goal: to provide support and information to pregnant mothers and those with newborns to three months old.*

Program and Demographic Information

Overview: This year 189 interventions (services) were provided to 169 unique families - some families participated in multiple services. The Parent-Child Dyadic Therapy Program (dyadic, trauma focused, and consultation) comprised 73% of the interventions provided to families. Chances for Children received 217 referrals and delivered 2047 sessions (dyadic and group) with an attendance rate of 80%.

Program Distribution:



Referrals: There was a 13% increase in referrals in 2022

	2021	2022
Referrals received	192	217
Referrals referred out or declined	45	62

Sessions: There was a 45% increase in sessions attended in 2022

	2021	2022	Increase
Sessions scheduled	1705	2568	51%
Sessions attended	1413 (83% attendance)	2047 (80% attendance)	45%

Interventions (Services):

	Dyadic Program	Group Program	Total
Assigned (pending opening)	4	0	4
Completed	65	25	90
Ongoing (open)	31	10	41
Prematurely discharged	22	4	26
Dropped out (< 5 sessions)	22	6	28
Total	144	45	189
Never began services*	23	7	30

Participant Demographics for Assigned Cases: (participants in dyadic and group programs).

Child Gender (171*)	Yes*	%
Female	81	47
Male	90	53

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

Parent Ethnicity (156*)	Yes	%
Latino	118	76
Non-Latino	27	18
Other	6	4
Unable to Obtain	5	3

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

Parent Race (156*)	Yes	%
American Indian or Alaska Native	5	3
Asian, Native Hawaiian, Other Pacific Islander	4	3
Black or African American	21	14
White or Caucasian	20	13
Latino**	15	10
Mixed Race	24	15
Other	36	23
Unable to Obtain	30	19

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

**A new self-reporting tool was implemented mid-year; therefore some racial and ethnicity data is overlapping.

54% of parents were in school or working or both, 44% considered themselves single parents, 56% reported a history of trauma, and 18% of participants had been or were involved with child protective services.

Other Information about Parents	N*	%
Single Parent	174	44
Parent Working	152	43
Parent in School	152	5
Parent Working and In School	152	6
Parent in Neither (Not Working or in School)	152	45
ACS Involved	131	18
Foster Care (Dyadic Only)	75	4
History of Domestic Violence	168	30
History of Trauma	156	56
History of Mental Illness	163	22
Current Depression	86	49
Child Delay/Referred Out	115	18

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

Evaluation of the Parent-Child Dyadic Therapy Program

The following measures are used to assess the efficacy of the Parent-Child Dyadic Therapy Program. The first three measures assess different aspects of parent, child, and dyadic behavior. The CES-D screens for depression and the PRFQ screens for reflective function.

- Pre-Post Intervention Video Coding (Baby Books 2 Coding Manual)
- Clinical Rating Scale (CRS)
- AMBIANCE-brief
- Center for Epidemiological Studies Depression Scale (CES-D)
- Parent Reflective Functioning Questionnaire (PRFQ)
- LookSee Checklist
- Exit Survey

Baby Books 2 (BB2) Pre-Post Intervention Video Coding: 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 *Intrusiveness, Sensitivity, Positive Regard, Language Quality, Language Amount, Stimulation of Development, Detachment, and Negative Affect*. For the child, it assesses *Positive Affect, Negative Affect, Responsivity, Language Quality, Language Amount, and Attention*. For the dyad, it assesses *Mutuality of Interaction*. Videos are coded by independent researchers not affiliated with CFC who are blind to the time of recording (pre- or post-intervention) and information about the dyad.

The Clinical Rating Scale: The Clinical Rating Scale (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. This tool is especially helpful to evaluate work with families who don't have access to video-based platforms. This tool can be used immediately following a session and allows us to monitor the progress of these families.

AMBIANCE-brief: This is a new measure introduced this year. AMBIANCE-brief measures problematic 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).² According to attachment theory, infants need caregiving that provides a secure base that can consistently modulate infant arousal. *“Without reasonably effective caregiver modulation of arousal, the infant is unable to organize a consistent strategy for using the parent as a source of comfort when under stress.”* (Madigan)³ The different behaviors that together comprise a pattern of insufficient caregiver protection are captured in the AMBIANCE. The clinical team underwent a three-day training in 2022 on the use of the AMBIANCE-brief, a recently validated measure for use in community programs.

Center for Epidemiological Studies Depression Scale (CES-D): This is a widely-used instrument that screens for individuals at risk of depression. Because depression in general, and perinatal depression in particular, is so prevalent it is important to capture its presence and severity quickly for further referrals if indicated. Our therapists complete this 20-item self-report measure with parents in either English or Spanish.

Parent Reflective Functioning Questionnaire (PRFQ): The capacity for a parent to “see the world through their baby’s eyes” and understand behavior (including their own and other adults’) as influenced by mental states (wishes, beliefs, thoughts) contributes to healthy relationships. It allows parents to think and reflect rather than to react impulsively. 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*. 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”*). The measure is administered by therapists in both English and Spanish and completed before and after the intervention to assess improvement.

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 treatment and administered by therapists in English and Spanish.

² 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>

³ Madigan, S. Atypical Maternal Behavior Instrument for Assessment and Classification AMBIANCE-brief: Manual for Coding Disrupted Affective Communication Version 1.0, September 26, 2018

Exit Survey: This survey is completed anonymously and is administered over the phone by an independent external researcher (outside of the CFC team). It consists of nine questions rated on a 1-5 scale of *strongly agree* to *strongly disagree* and includes a comments section. The survey gives a general picture of client satisfaction with services, the help they received, their relationship with their therapist, and whether receiving services from Chances for Children has relieved stress and isolation. The survey is given to parents who completed either dyadic therapy or group services. These results can be found at the end of the Group Program section of this report.

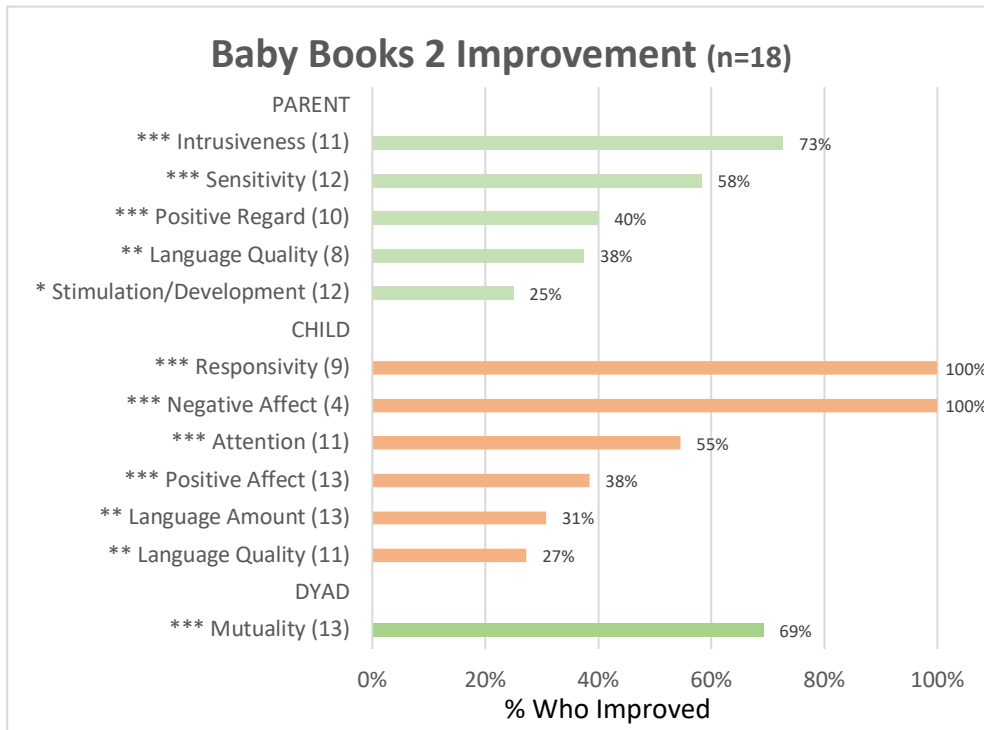
Parent-Child Dyadic Therapy Program Results

Video Analysis Results: Video recording has been an important part of Chances for Children’s model from its inception, and the coding of pre-post intervention videos has been one measure of our efficacy. Early in the COVID-19 pandemic, video recording was not possible; however, mid-year this year we were able to implement the coding of videos recorded on Zoom with 18 families who had access to WiFi and internet. As always, particularly among the families in our severe trauma focused therapy program, video recording is not always advisable. Coding of videos was completed by independent researchers, blind to time of recording (pre- or post- intervention) and family information, using the Baby Books 2 Coding Instrument. Baby Books 2 contains coding schemes for parents and children in free play episodes, designed to meet different developmental levels of children as they age. It assesses factors for the parent, the child, and the dyad.

The recording of parent-infant interaction on Zoom is complicated in many ways and as a result leads to challenges in coding. The spreadsheets delivered by our coders included comments such as *“Background loud, hard to hear interaction”*, or *“Mother had mask on so difficult to see facial expressions”*, *“Mother holding camera which could have prevented her from engaging physically with the child more.”* We also saw behavioral differences in Zoom-recorded videos from videos recorded in person; for instance, we saw no examples of parent negative affect among the videos coded this year as well as very little parental detachment. For this reason, some items had too small a sample size to assess change. The results reported are on items in which change could be assessed. Results should be considered in light of these limitations.

Baby Books 2 (BB2) Coding Results: Statistical testing was done to determine whether a behavior had improved after the intervention. In those individuals who had a problem in that behavior at baseline and needed to improve, we tested whether their score went from *poor* to *good* using a one-sample binomial test. ***Across all measures these parents and children improved.***

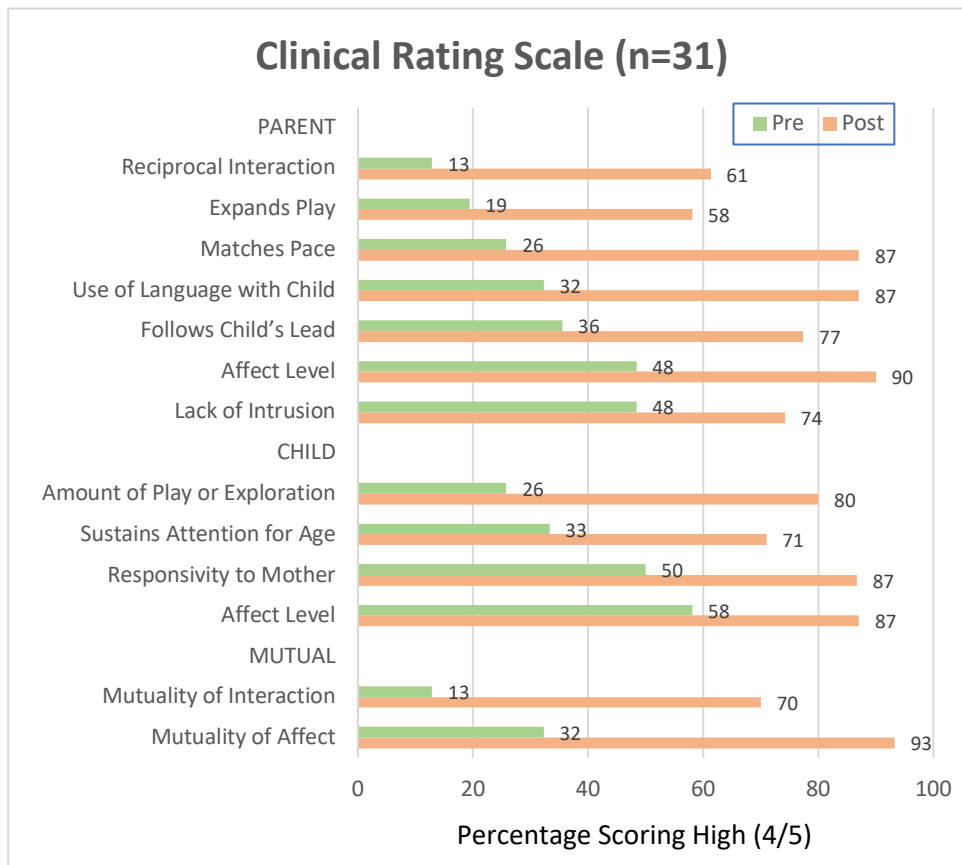
Individual items for Baby Books 2 are coded 1-5 or 1-7. On this spectrum those at the midpoint or further in the negative direction were deemed to be *“poor”*. (For example: *Parental Positive Regard*, scores of 1, 2, or 3 were coded as *“poor”*.) Of the 18 dyads we coded in 2022, the number of parents or children showing problems in each area varied. The number of parents and children showing *poor* scores at baseline is indicated after each item on the bar chart below. Of those individuals who had scored *poor* at baseline, the length of each bar represents the percentage who had improved to *good* after the intervention.



* $p < .05$, ** $p < .01$, *** $p < .001$. Note: Percentage improved of those who scored “poor” at baseline.

The number in parenthesis after the separate items refers to the number of individuals who had a problem in this area. For example, there were 12 parents whose *Sensitivity* was *poor*. Of these, 58% (7/12) showed improvement such that *Sensitivity* was *good*. This improvement was statistically significant, shown by the three asterisks. **Improvements in all areas were statistically significant.** *Detachment* (2), *Parental Negative Affect* (0) and *Amount of Language* (4) were not included due to small numbers of individuals who exhibited *poor* behavior for these items.

The Clinical Rating Scale (CRS) Results: During the first year of the pandemic, Chances for Children developed the Clinical Rating Scale which allowed therapists to code a virtual session with parent and child at the end of the session. We have maintained this practice of assessment this year for all families even as we have introduced Zoom recorded sessions as this allows us to assess progress for families with or without access to WiFi or internet. Thus, we have two sets of data to report this year with similar constructs. We have CRS pre-post intervention results on 31 dyads.



Bar Graph Explanation: The horizontal bar graph above illustrates the levels of need and levels of improvement after interventions. Green 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=31) 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- telehealth assessments that were recorded. For example, for parent reciprocal interaction, at the first telehealth assessment, only 13% rated *high/very high*. At the latest telehealth assessment recorded, 61% 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 the item.**

Correlation Between CRS and BB2: As illustrated above, we have used two methods of evaluating clinical outcomes: the Clinical Rating Scale (CRS) which allows for coding without video recording and Baby Books 2 (BB2), based on video recordings. Since the CRS is coded by the treating therapist directly after the session, we wanted to ensure that there were no coding biases in the scores. To address this, team coding of available videos was done periodically. In addition, we wanted to assess whether the CRS, created in house, could be considered valid. (That is, does the measure validly reflect the intended construct?) To understand this, we considered the relationship between items on the CRS and items on Baby Books 2. **We found that all CRS items, coded by the treating therapist, correlated moderately or strongly with independently scored items on BB2.** This validated the Clinical Rating Scale items. (For example, on CRS, the more strongly a person was rated as *Intruding* the LOWER their scores on *Stimulating Development* ($r = -.84$) and on *Sensitivity* ($r = -.65$) in Baby Books 2. These correlations confirmed that the CRS items were properly related to

items in BB2 that should be correlated and failed to correlate with items that should not have correlated. This validates our use of the CRS. (All statistical analyses are available on request.)

AMBIANCE-brief Results: Our videos were coded pre- and post-intervention for level of problematic 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*.

A total of 44 videos (22 dyads pre/post) were coded in 2022. AMBIANCE-brief results show that at Time 1, 11 parents (50%) displayed disrupted behaviors predictors for disorganized attachment in the child. After participation in the CFC program, at time 2, no parents displayed disrupted behaviors and ***all parents were able to alter their caregiving sufficiently to meet criteria for non-disrupted caregiving***. All parents were able to modulate infant arousal adequately, thus reducing risk of disorganized attachments.

In the past, CFC has not had a measure of attachment because the measures were too costly and time intensive. This measure gives us a picture of behavior that predicts likely development of the most worrisome attachment organization. It appears that the intervention has been able to address these behaviors sufficiently to move parents out of the most concerning category.

Center for Epidemiological Studies Depression Scale (CES-D) Results: Of 87 parents, 42 (36.54%) parents screened as indicating possible depression. The clinical team is continually assessing whether or not a parent is depressed. The clinical assessment, and the results of the CES-D are considered and a referral to appropriate treatment is made when necessary.

Parent Reflective Functioning Questionnaire (PRFQ) Results: The PRFQ has three subscales: *Pre-Mentalizing*, *Certainty of Mental States*, and *Interest and Curiosity*. Desired scores on the PRFQ are *low Pre-Mentalizing*, a *moderate* level of *Certainty of Mental States*, and a *high* level of *Interest and Curiosity*. ***All three subscales show change in the desired direction after the intervention***. That is to say that after the intervention, parents are better able to “keep their child’s mind in mind” and to reflect from the child’s perspective. Note: For this measure, we are looking for *Pre-Mentalizing* to *decrease*, for *Certainty of Mental States* to be mid-range and for *Interest and Curiosity* to *increase*. A paired t-test was used to assess change.

PRFQ 2022					
	Pre M (SE)	Post M (SE)	t (df)	p-value	Effect Size
Pre-Mentalizing	2.79 (.27)	1.54 (.11)	5.053 (30)	<0.001	.46 (Large)
Certainty About Mental States*	3.56 (.24)	4.05 (.26)	-1.764 (30)	0.088	.09 (Small)
Interest & Curiosity	5.66 (.22)	6.48 (.12)	-3.878 (30)	0.001	.33 (Medium)

* Items 11 & 14 removed from *Interest & Curiosity* to achieve good reliability

The LookSee Checklist Results: 21 children screened for developmental delays. Of those not already receiving services, 6 children were identified as needing referral to Early Intervention services and referrals were made.

Exit Survey Results: These results are reported at the end of the Group Program section (see page 18-19) as dyadic and group participants are screened anonymously using the same survey and results are aggregated.

Parent-Child Dyadic Therapy – A Family Story

Sometimes referrals come to Chances for Children for fathers who are the primary caregivers for their children because the child's mother is incapacitated or cannot be found. In other situations, fathers are referred because they deeply want to be part of their child's life even if they are not the child's primary caregiver. Here is the story of Jason and Faith.

Jason was persistent in his efforts to find a way to be a father to his daughter. Raised in foster care himself, Jason was determined this would not be his daughter's future. He and his daughter's mother, Celeste, had planned: Jason had the opportunity to work a short-term, well-paying job in the South which would end shortly before the baby's birth. This would allow the family to settle in their own apartment upon his return, particularly important because Celeste was legally blind and somewhat physically limited. Jason had planned to work nights to support them and be home with Celeste and baby during the day. Baby Faith, however, was born prematurely and with a positive toxicology. Jason was out of state and "could not be reached". As Faith could not be released to her mother, Child Protective Services became involved, and Faith was discharged to Celeste's Aunt.

Faith remained in foster care for two years while Jason struggled with family conflict, Child Protective Services, and a court system stalled by COVID-19 shutdowns, to gain access to his daughter and build a relationship with her. Faith was a tiny girl with long black braids, a toothy smile, and large, round, red-framed eyeglasses with thick lenses that gave her the appearance of being bewildered. Faith was still living with her aunt when we met Jason who in his determined, tireless way had found Chances for Children and referred himself to our program. Faith was finally able to have regular visits with her father.

As their first video began, it was hard to say who was more at sea. Faith wandered around among the toys with her back to her father while he followed her around clumsily, alternating bursts of anxious conversation with silence. Eventually Faith picked up a doll and still with her back to Jason, handed the doll to him by its leg. As he took it, she busied herself exploring a play kitchen. It seemed as though she might be asking, *"So? What are you going to do with this baby?"*

Finding himself surrounded by playmats and toys, holding a plastic doll's leg, Jason raised his eyebrows, took a deep breath and plunged in. *"You cookin'?"* he said putting down the doll. *"Makin' some dinner?"* Faith looked up at him briefly, picked up the doll, handed it back to him and turned back to the dishes.

Spotting some blocks, Jason put the doll down and began building. *"Help me build a tower, Faith. C'mon, help me?"* Faith picked up the doll, handed it back to Dad and turned away. *"You wanna*

read a book, Honey?" said Dad, as he put down the doll and picked up a book. Faith looked around, picked up the doll, picked up a toy bottle and stood in front of Jason, staring at him. Then she dropped both in his lap and waited. Slowly Jason picked up the baby and the bottle and started to feed the baby. Faith grinned from ear to ear and plopped down next to them watching. It seemed that Dad had gotten the message: he was going to feed his baby.

Jason wanted deeply to be a dad to Faith; he was struggling to build connection, feeling more and more inadequate. Having this interaction on video to watch and reflect on together, seeing the same persistence in Faith as in himself, gave him hope that if he listened, Faith would show him what he needed to know, as she did in this interaction.

Over time, as they played with babies, became Princesses and Kings, and created doll-house stories, Faith and Jason forged a strong bond that held through family conflict, court proceedings, and custody battles. Jason and Faith continue to find their way together.

Evaluation of the Group Program

Growing Together Group Program

The purpose of the Growing Together 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 COVID-19 pandemic, and telehealth groups continue to be appreciated by families who remain reluctant to be in-person. We are hopeful though, that our in-person groups will flourish again soon. These groups are held in Spanish and English by bilingual therapists. Evaluation of the Growing Together Group Program is predominantly qualitative and descriptive with quantitative data from our Exit Survey (described above; results reported below).

Six groups of parents and babies were held in 2022. Groups ran from 5-12 sessions each for one hour and were conducted by telehealth (Zoom). All groups were bilingual and ranged from 4 dyads 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) hello/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.

One mother remarked: *“The group feels like my other family where I can share different experiences and topics that are intimate.”* Another reflected: *“It feels like our words are held in your mind.”*

Growing Together Group Program Vignette (from the theme of *Connection Through Play*)

During our fall session, one of our favorite play activities was for each mother and baby to collect leaves together to turn into a collage during group. One mom shared collecting a leaf that looked

like a heart; she described it as a coincidence, for “*when you do things from the heart, they turn out well.*” Another mom talked about how calming this activity was for her and baby, and how she hoped to recreate it together when they see more leaves.

Empowering Motherhood Group Program

This group was piloted in 2021 to provide emotional support to pregnant mothers and mothers with newborns using an infant mental health perspective that encourages secure attachment and a reflective stance. The success of these groups was reflected in the feedback received from the parents and became a feeder program for our Growing Together Groups, which parents were encouraged to join after giving birth.

Four groups were held in 2022. Four to nine pregnant mothers and mothers of newborns met with an infant mental health therapist facilitator on a weekly basis for 6-8 sessions lasting ninety minutes each. This group was conducted in English and Spanish by a bilingual therapist.

As with all groups, this group followed 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.

In 2022, we introduced a new measure to assess the efficacy of the group intervention. A questionnaire assessing parental knowledge of perinatal information was administered in Spanish at the onset of the group and at the end. The questionnaire consists of 12 True/False questions such as: *a parent’s mental state can affect a baby when she is pregnant, babies can sense their mother’s moods, and at four-months-old, babies can play.*

This chart describes the percentage of *correct* responses of the parents at pre- and at post-test.

Statement to be answered true or false	correct answers pre	correct answers post
At four-months-old, babies can play.	90%	100%
Talking to babies makes them smarter.	75%	100%
Babies cannot let us know what they want before they can talk.	60%	100%
A parent’s mental state can affect a baby when she is pregnant.	50%	100%
You can spoil a baby by picking him up when he cries.	50%	88%
The relationship between a parent and child begins at birth.	40%	88%
Soothing touch strengthens a baby’s brain.	30%	100%
Babies can sense their mother’s moods.	30%	100%

Of the initial 12 questions, 3 were answered correctly by all parents at both pre- and post-test (those results are not included in the chart above). At the post-test, of the remaining 9 questions, 7 were answered correctly by all parents, and 2 were answered correctly by 88%, and in one question the data was corrupted (not included). This indicates a positive change in how participating mothers attending this group understand perinatal development. The following vignette illustrates another aspect of the group program: the critical role that social support can play.

Meet Our Empowering Motherhood Group

Sonia was in her last trimester of pregnancy when she came to our Empowering Motherhood Group. As she introduced herself to the group, she spoke of her six-month journey with her husband to the Bronx from the very south of South America, sometimes walking, other times traveling in whatever form of transport was available. Their journey was endless and dangerous. When Sonia arrived in the Bronx, she discovered she was in her second trimester of pregnancy and was filled with angst, and at times, despair.

As a first-time mother she thought anxiously aloud, *“How do you care for a baby? What do you do with all the feelings that you did not expect to have? The difficult ones!”*

Josefa, spoke up. *“Sonia, you know, you are a first-time mom... and this is my fourth child! I always had all these feelings that surprised me – really surprised me. When I came here, I learned these are feelings that we can talk about.”*

Another mother continued *“...and all the moms help you to understand them. I have them too! This is my second baby!”*

With great and visible emotion, Sonia said, *“...so all these feelings... you know... I am so ashamed and scared of having them... you have them too?”*

Namira broke in, *“Yes, all moms have them, but no one tells you. We can talk about the feelings and they do not mean you do not love your baby. We learned that when we take care of our feelings, we are saying to our baby, “I love you; I can be with you even when it is hard... I can sing to you with more love after I take a little time to understand myself.”*

Sonia replied, *“All this time, I have felt so alone and when I learned here that your relationship with your baby begins in the belly... I...”* Her eyes filled with tears. All of the mothers leaned into her from their little Zoom windows and made hearts with their hands.

Another mother spoke up, *“Yes, the relationship with our babies begins in the belly, that is the beginning and little by little we can be the moms our babies need. We need to listen to them first, but also to ourselves... and little by little “we” grow together... even when it is hard!”*

Exit Survey: Combined Results from Dyadic and Group Program Participants

Exit surveys were collected from 67 dyadic therapy and group program participants. Not all parents could be contacted; however, three attempts were made to reach each family. The following questions were rated from *strongly agree* to *strongly disagree* or *not applicable*.

	Strongly Agree	Agree	Disagree	N/A
I look forward to speaking with my therapist.	78%	16%		6%
Chances for Children offered me strategies and activities that help me play with my child and support her/his development.	82%	13%		5%
I feel like I understand my child better since receiving services from Chances for Children.	66%	28%		6%
It is easier for me to find words to explain things to my child.	66%	31%		3%
Participation in Chances for Children program has helped me feel less stressed.	79%	15%	3%	3%
Sessions with my therapist have helped begin to resolve the problem that brought me to Chances for Children.	64%	33%	2%	1%
I would recommend Chances for Children services to other families.	78%	16%		6%

Parent Comments Expressed in the Exit Survey

Below are some comments that parents expressed at the end of the Exit Survey when asked what they might remember about their experience with Chances for Children (each comment is first noted in the language in which it was expressed):

- ***“I was worried about my child and now I feel more relaxed; I give my child the time and freedom to reach milestones on her own.”***
- ***“Me han ayudado a romper el ciclo de mi generación y audó con la comunicación. Ser padre solía sentirse como una tarea, pero aprendí mucho. El grupo ha plantado una semilla en mí y ahora puedo crear un espacio seguro para mis hijos y ayudarlos cuando se conviertan en padre.”*** ***“They have helped me with breaking the cycle from my generation; helped me with communication. Being a parent used to feel like a chore, but I learned a lot. The group has planted a seed in me, and I can now create safe space for my children and help them when they become parents.”***
- ***“Me gusta la convivencia que hacen con los demás padres. Aprendo de las experiencias de los demás padres con sus hijos. Si ellos han pasado por algo, yo puedo aprender y saber que hacer si lo mismo me pasa con mis hijos.”*** ***“I like the harmony that they create with the other parents. I learned from the experiences of other parents with their children, if they have gone through something. I can learn and know what to do if the same thing happens to me with my children.”***
- ***“How wisely supportive and understanding the therapist was, and how much my child looked forward to seeing her.”***
- ***“Me enseñó a manejar las cosas. Tenía empatía y nunca la ví como que tuvo mal día, siempre disponible, empática, me entendía, me daba alivio, refugio y siempre tenía delicadeza. Como cosa de familia.”*** ***“My therapist taught me to handle things. She had empathy and I never saw her as having a bad day, always available, empathetic. She understood me; she gave me relief, refuge, and she was always gentle; like a family.”***

- *“Do me aconsejaban, lo hicieron de una manera que no me sentia mal ni culpable, no me sentia como una madre mala.” “They guided me; they did it in a way that I didn’t feel guilty. I didn’t feel like I was a bad mother.”*

Supporting Collaborating Partner Organizations

Our clinical team provides consultation and training to early childhood and early education professionals and paraprofessionals working for organizations within the community. Our goals are to infuse infant mental health principles into these programs, to support early childhood practitioners and the parents they serve in dealing with pandemic, personal, and environmental stress. In addition, we provide introductory presentations about the Chances for Children program to parents engaged with collaborating partners.

During 2022, our clinical team provided:

- 5 presentations introducing Chances for Children Services: attended by 191 participants.
- 4 parent workshops: attended by 66 participants.
- 6 interactive virtual trainings: attended by a total of 363 participants.
- 3 virtual open houses attended by foster care workers, nurse practitioners, other early childhood professionals, and funders.
- Regular weekly reflective consultation and relational developmental guidance to directors, teachers, and early childhood professionals at McCloskey Early Head Start Home-Based Program: 4-6 hours per week. Directors were seen as a team and Early Head Start teachers and family workers were seen individually.

Conclusion

2022 has been an exciting, challenging, and rewarding year for Chances for Children. Our outcomes continue to be positive as we emerge from the aftermath of the pandemic into a new normal. The return of some families to in-person services has been profoundly revitalizing even as we sort out the challenges. We have expanded our clinical team and anticipate new collaborations. Our group program has grown; new initiatives that we piloted are flourishing. Overall and across the full range of evaluation measures we achieved positive outcomes.

Our leadership, Co-Executive Directors Silvia Juarez-Marazzo and Lillian Rountree, and our administrative team have created systems without which our clinical work could not thrive, and that solidly scaffold our therapists. Critically the families engaged in our services remain eager, enthusiastic partners who continue to teach us new lessons each year. These lessons continually inform and transform our clinical work.

We have much to be grateful for moving into 2023. We look forward to two presentations of our work at international conferences, as well as a publication in a psychoanalytic journal. We remain deeply grateful to our funders and the members of our Board of Directors for their support, responsiveness, energy, and enthusiasm for the mission of Chances for Children, the families we serve, our team, and the work that we do.

Thank you!