

Supporting Positive Parenting for Young Children Experiencing Homelessness

The PACT Therapeutic Nursery

ALISON HEINHOLD MELLEY

KIM COSGROVE

Kennedy Krieger Institute, Baltimore

CAROLE NORRIS-SHORTLE

LAUREL J. KISER

University of Maryland School of Medicine

ERIC B. LEVEY

Johns Hopkins University School of Medicine and Kennedy Krieger Institute, Baltimore

CATHERINE A. COBLE

University of Maryland School of Medicine

AUDREY LEVITON

Kennedy Krieger Institute, Baltimore

The PACT: Helping Children With Special Needs' Therapeutic Nursery (the Nursery) serves families who have at least one child from birth to 3 years old and who are living in a Baltimore City shelter. High quality day care services are provided in partnership with Early Head Start while parents look for housing and employment. In addition, the center offers a mental health program and several other services including speech and language therapy, occupational and physical therapy, and nurse practitioner services. Parents are encouraged to stay in the Nursery with their children whenever they are able and to take advantage of the parent-child activities that are offered. The goal is to improve the child's resilience during and after the stress of homelessness and shelter living by increasing parents' sensitivity to the needs of their child.

Consistent with national statistics (National Alliance to End Homelessness, 2007), the families in the Nursery are primarily headed by young single mothers, typically with less than a high school education. The mothers are often caring for more than one child and have difficulty meeting basic needs

for themselves and their children. In a 2006 study, of 99 children from the Nursery, we found that 42% showed significant language delays and 40% showed delays in play development (Norris-Shortle et al., 2006). The same study showed that 32% of parents and children were identified as having a "problematic"

Abstract

Sensitive parenting and secure attachment can serve as protective factors against developmental risks associated with high-risk environments such as homelessness and shelter living. This article describes a program for mothers with children from birth to 3 years old whose families are living in shelters and who are enrolled in PACT: Helping Children With Special Needs' Therapeutic Nursery program. The authors describe the interventions designed to increase positive parenting behaviors to foster healthy parent-child interaction and then present a research study that examined how maternal participation in these interventions is related to improved parent-child interaction.



PHOTO: MARILEY NOLT

The challenges of homelessness and shelter living can be buffered by positive parenting behaviors.

attachment relationship. These early challenges that homeless and shelter-housed children encounter have immediate and long-term consequences for young children, (Koplow, 1996; Rubin, Bukowski, & Parker, 1998; Schaefer, 1980) but might be buffered by positive parenting behaviors (Pettit, Bates, & Dodge, 1997). Interventions built into the therapeutic environment at the Nursery address these and other needs for parents and young children.

Mental Health Interventions

THE OVERARCHING GOALS of the Nursery's mental health program are to enhance the parent-child relationship and to support and create rituals and routines within the family unit. In the early childhood intervention literature, a consensus exists among researchers that parenting and family home environment are considered the most important influences in the child's emotional development (Davenport & Bourgeois, 2008; National Research Council & Institute of Medicine, 2000). In addition, there is strong empirical evidence demonstrating that the constructive use of family rituals is linked to family health and resilience and to psychosocial adjustment in children (Braithwaite, Baxter & Harper, 1998; Markson & Fiese, 2000; Viere 2001). In families who are living in shelters, the continuity of family rituals can act as an emotional scaffold during a time of adversity. Through its routines and supportive family rituals, the Nursery provides a safe physical and emotional envi-

ronment designed to decrease separation anxiety and allow for exploration and predictability (Koplow, 1996). Child care staff provide opportunities for children to learn to anticipate events through structure and routines, and they coach parents and children in skills that will foster positive interactions. For example, staff coach all parents to say a clear good-bye to their child when leaving, not to sneak out, and to greet their children with a warm welcome upon return.

All activities and interventions in the Nursery are focused on strengthening family rituals and routines and on demonstrating sensitive, responsive, and growth-fostering parenting behaviors. Formal interventions are individualized to benefit families who often experience the stress of homelessness in a variety of different ways. With this population it is especially important to be family-centered and to tailor interventions to the individual strengths and needs of each parent and child (Bassuk, Weinreb, Dawson, Perloff, & Buckner, 1997; Kelly, Buehlman, & Caldwell, 2000). The current paper focuses on six interventions that are utilized most frequently with the families in the Nursery.

Weekly Parent-Child Therapy Sessions

Each family has the opportunity to work with a licensed clinical social worker, at a time that is convenient for the parent. This intervention uses video-feedback with the Nursing Child Assessment Satellite Training (NCAST, Sumner & Spietz, 1994), and was described in more detail in Norris-Shortle et al. (2006).

Separation Practice

Children who are experiencing separation anxiety are engaged in separation practice with their parent to help the child learn that their parent will return. This is a two-clinician model in which parents are coached to say a clear good-bye, then accompanied by a clinician to leave for 30 seconds while another clinician comforts the child. Upon reunion, the parent gives a warm welcome and parent and child are comforted. Another slightly longer separation is attempted, and then again a third time, depending on the level of distress the child experiences.

The remaining four interventions described below are held on the same morning once a week, and were developed based on Kiser's (2001) Strengthening Family Traditions group intervention model.

Family Ties Breakfast

In order to provide parents and children with an opportunity to enjoy the ritual of the family meal, breakfast is provided once a week in the Nursery. Family members sit together, the parents serve their children, and then the staff and clinicians serve the parents (nurturing the parents). To help parents increase their skills in engaging their young children in table conversation, staff and clinicians sit with each family group and use strategies to stimulate conversations between parents and their pre- or early-verbal children. For example, staff leaders will encourage a parent to talk about the food they are offering or about what they are going to do that day. In addition, staff members focus attention on the child's cues with comments such as "Ms. Smith, it looks like your toddler is sneaking up on that new fruit and tasting it." Finally, staff members might talk for the child, for example, "Mommy, I love it when you sit beside me and eat. It makes my breakfast taste better." Parents experience how talking to their young child and listening to the responsive babbling can be important in promoting cognitive and language skills.

Attachment-Based Circle Time

The goals of circle time include both enhancing the parent-child attachment as well as increasing learning and language development. Children and parents use photographs of themselves to promote both their attachment and self-identity. The children choose the songs to be sung, many of which are centered on relationships. The songs are paired with hand gestures or symbols that the children can hold and explore. Another opportunity for strengthening attachment exists when the parent learns the hand gesturing along with her child. The children also choose the storybook to be read. One of the children's favorites is the Nursery's *Beautiful*

Copyright 2010 ZERO TO THREE. All rights reserved. For permission to reprint, go to www.zerotothree.org/reprints given the opportunity to create and share a Mandala that represents what family means to them.

Children Book, featuring an 8 x 10 photo inch of each parent and child, inscribed with the parent's loving description of her child. This book is particularly comforting for the children who are going through separation anxiety, as an important visual reminder that their parent comes back.

Parent–Child Activity

The goal for the parent–child activity is to provide an experience for the child of receiving their parent's full positive attention. The parent has a rare opportunity to focus on her child and take the time to delight in her child's interests and abilities. These goals are accomplished by providing the parent–child dyad with a very simple stimulus activity such as collage, sculpting clay, peek-a-boo, painting, or mirror play. Staff members encourage the parent to sit face-to-face with the child and to follow the child's lead and label the child's actions (watching then replicating the child's movements). A clinician sits with each parent–child dyad to provide guidance and support during what can be a difficult task for a parent. The therapist's role is to hold the focus on the child's lead, highlighting the engagement and disengagement cues that might be overlooked by the parent. Concepts from Bell and Eyberg's (2002) Parent Child Interaction Therapy and Proulx's (2002) Parent–Child-Dyad Art Therapy are incorporated into this activity time. The conclusion for this activity occurs when the parent, with support of the therapist, recognizes the child's subtle disengagement cues and stops the activity with a clear statement like “you are all done now,” which is an important step in helping the child make a smooth transition to his next activity.

Parent Group

A parent psychotherapy group, held weekly, allows parents the opportunity to explore topics related to their own family traditions and daily life struggles as well as to gain confidence in their own ability to successfully read their child's cues. The group facilitators are licensed clinicians who ensure the group's environment is safe to promote positive parent-to-parent support. Calming music is played in the background to help stressed parents feel more relaxed, and the group begins with a general discussion about being respectful and supportive of the other group members. Facilitators use brainstorming techniques to help families learn from each other and hands-on activities to provide parents an opportunity to learn and explore. Topics might be specific to concepts such as engagement/disengagement cues or keeping the parent's family safe, or they might be broader to allow for exploration of the meaning of family. For example, parents are

How Does Program Participation Affect Parent–Child Interaction?

RESearchers at the PACT Nursery are interested in finding out how the intervention affects the quality of parent–child interaction because the parent–child relationship is expected to impact children's development (Administration for Children and Families, 2002). Results of the first outcome study (Norris-Shortle et al., 2006) showed that, during the few months families were enrolled, parent–child interaction scores improved and that the families with the lowest scores improved the most. Mothers were able to acquire and demonstrate increased positive parenting behaviors. There is great variability, however, in maternal participation in the mental health program and in the level of parent–child relationship improvement. In the study described below, we wanted to know whether the amount of time mothers spent engaging in the mental health program is an important factor in treatment outcome, and we wanted to investigate further the finding that the families with lower parent–child interaction scores at enrollment improved the most.

We expected that the more time mothers spent participating in interventions, the more their parent–child interaction scores would improve. We expected that time spent in parent–child therapy sessions would have the strongest relationship to improvement

because during these sessions clinicians focus specifically on increasing the skills that are measured on the parent–child interaction assessment. We also predicted that parent–child interaction scores would increase in all of the different areas of parent–child interaction but would improve the most in parenting behavior subscales. This prediction was based on the fact that Nursery interventions are focused mostly on coaching mothers to change their behavior to benefit their children.

Participants

We invited mothers to participate in the study shortly after they enrolled their children in the Nursery. The current study included data from 87 caregiver–child dyads. Children ranged in age from 2 weeks to 3 years, and mothers' ages ranged from 17 to 39 years. Of the children in the study, 57% were males, and 95% were African-American. Twelve of the mothers were currently pregnant, and 61% of families had more than one child living with them in the shelter. In addition, 38% of mothers had at least one child who was not living with them, and 37% of fathers of the children in the study were at least minimally involved in the child's life (according to mother). Maternal education ranged from 8 years (through 8th grade) to 16 years. The average length of stay in the Nursery is 11 weeks.

Measures

The measures used in our research are part of typical care in the Nursery. The goal



PHOTO: ©STOCKPHOTO.COM/ISAAC KOVAL

The continuity of family rituals can act as an emotional scaffold during a time of adversity.

of the research project was to make use of the data that were already being recorded in order to understand and improve upon our therapeutic work.

Parent–child interaction quality.

Nursery staff assessed parent–child interaction quality with the NCAST (Sumner & Speitz, 1994). The NCAST is an assessment and clinical tool that involves a videotaped teaching session with the parent and child. Mother and child behavior is videotaped during the first and last parent–child therapy sessions. Behavior is coded by clinicians and researchers who have been trained in the use of the NCAST and certified reliable with the developers of the instrument. Coders are randomly assigned, the same coder does not score both pre- and post-intervention videotapes, and the majority of coders do not work with the families in the Nursery.

Coders can calculate a single NCAST Total score for the mother and child, both separately or in combination. The coders can also calculate subscale scores, consisting of six components of the parent–child interaction. Caregiver subscales are based on the mothers’ behavior only and include (a) Sensitivity to Child’s Cues, (b) Response to Child’s Distress, (c) Social–Emotional Growth Fostering, and (d) Cognitive Growth Fostering. Child subscales are based on the child’s behavior only and include (a) Clarity of Cues and (b) Responsiveness to Parent. The Contingency subscale considers behaviors of both mother and child—one must display a cue and the other must respond in order to score positively on this scale. Higher scores indicate that more positive behaviors were displayed.

Maternal participation. We defined maternal participation as the number of hours spent engaging in Nursery interventions. The number of hours included parent–child therapy sessions, separation practice, attachment-based circle time, family ties breakfast, parent–child activity, and parent group.

NCAST change scores. We calculated a change score by dividing the change in parent–child interaction NCAST scores by the pre-intervention score: (i.e., $[(\text{post-intervention score} - \text{pre-intervention score}) \div \text{pre-intervention score}]$).

Results

We used the above measures to study the relationship between the amount of time mothers spent in the interventions and their NCAST change scores.

CHANGE IN PARENT–CHILD INTERACTION SCORES (NCAST)

At the first parent–child therapy session (pre-intervention), 40% of mothers and 3%

Results of the regression analysis showed that the pre-intervention NCAST scores “explain” 65% of the NCAST change scores and that all parental participation variables together “explain” an additional 8% of the NCAST change scores.

of children scored below the 10th percentile on the NCAST, which has been defined as the clinically relevant cutoff to identify “worrisome” cases by the developers of the NCAST (Sumner & Speitz, 1994). At the final therapy session (mean of five 1-hour sessions), only 9% of mothers and 1% of children scored below the 10th percentile. We divided the mothers into two groups: *low scorers* were those who scored below the 10th percentile cutoff score on the NCAST Caregiver scale at pre-intervention (the bottom 40% of the distribution), and *high scorers* were those who scored in the highest 40% of the distribution. We divided the groups this way to obtain equal comparison groups and to prevent mid-range scores from obscuring differences between groups. High and low scorers did not differ on demographic characteristics such as maternal or child age, child gender, or maternal education.

Caregiver NCAST scores increased significantly more for the low scorers than for the high scorers. Child NCAST scores repeated this finding, with low scorers improving more than the high scorers. Because we are most interested in caregiver behavior in this analysis and only 3% of the children were in the 10th percentile cutoff group (the highest risk group) at pre-intervention, we utilized the Caregiver NCAST scores for further analyses (rather than Child-only or Child–Caregiver Total NCAST scores).

MATERNAL PARTICIPATION

Overall, mothers spent the most time in the family ties breakfast, with parent–child therapy sessions a close second. Because the high- and low-scoring mothers differed considerably in their outcome in the Nursery, we

wondered whether they also differed in their use of the interventions. We found that the low-scoring group spent significantly more time at the family ties breakfast and attachment-based circle time.

The amount of time that mothers spent in the family ties breakfast, attachment-based circle time, parent–child activity, and parent groups was significantly correlated with change scores, indicating that those who spent more time in these interventions showed more improvement in their parent–child interactions. The Caregiver NCAST scores at pre-intervention had the strongest correlation with change scores, confirming the finding that those with the lowest initial Caregiver NCAST scores improved the most.

MATERNAL PARTICIPATION AND NCAST CHANGE SCORES

Simple correlations, as described above, cannot tell the full story because they can use only two variables at a time. For example, correlations told us that time in the family ties breakfast is related to change and also that time in parent group is related to change but not how time spent in the two interventions are together related to the NCAST change scores. Multiple regression analysis is a statistical tool that allowed us to analyze how several variables together are related to the NCAST change score, and we calculated how much each variable contributed to “explaining” the change score.

Results of the regression analysis showed that the pre-intervention NCAST scores “explain” 65% of the NCAST change scores and that all parental participation variables together “explain” an additional 8% of the NCAST change scores. Participation in parent–child therapy and parent group were the most significant contributors to change.

Further analyses using the NCAST subscale scores revealed that the high-scoring group showed almost no change in subscale scores, with the exception of the Cognitive Growth Fostering scale. The low-scoring group, however, showed improvement in all subscales, but especially on Cognitive Growth Fostering and Parent–Child Contingency.

Discussion

THE RESULTS OF the current study generally supported the hypotheses.

As expected, all parent–child interaction scores improved with time, and those dyads with lower initial scores improved the most. We had not anticipated the strength of this last result, however. When we split the mothers into two groups—those with the lowest initial parent–child interaction scores and those with the highest scores—we found that the groups were quite different.

The low-scoring group showed improvement in all subscales while the high scoring group showed almost no improvement in their scores. The parents with the lowest parent-child interaction scores when they first enrolled did spend significantly more time in the interventions, specifically in family ties breakfast and the attachment-based circle time. However, this difference in participation does not fully explain the differences in improvement, because parent-child therapy sessions and parent group were the most strongly related to improvement in parent-child interaction. Also, although the correlations with just two variables indicated a strong association between maternal participation and improvement in parent-child interaction scores, when we used regression analysis to consider all of the variables together, the contribution of maternal participation was diminished.

There are several possible explanations for the differences in the high- and low-scoring groups. At pre-intervention, the high-scoring mothers were already demonstrating many parenting behaviors that were sensitive, responsive, and stimulating, as evidenced by their NCAST scores. The low scorers on the other hand, had more room for improvement. With intervention, the low-scoring mothers increased their positive parenting behaviors, thus dramatically increasing their NCAST scores. The high-scoring parents might also have increased their positive parenting behaviors, but the assessment instrument requires only that the parent display a behavior once to score positively, and multiple similar behaviors during a session are not considered. In fact, at post-intervention, scores are very similar for the high- and low-scoring groups. At post-intervention, very few mothers fell below the 10th percentile cutoff score.

Another explanation might be that mothers with fewer positive parenting behaviors at enrollment also had more needs of their own, leading them to spend more time participating in interventions. Mothers were nurtured themselves while in the Nursery, and those with more needs may have engaged in the mental health program because their own needs were being met. It is also possible that, although child care staff do not have access to parent-child interaction scores, they may intuitively have known which parents and children needed more attention and might have spent more time engaging those parents.

Finally, a more practical explanation is that parents with higher parent-child interaction scores might also have had higher functioning in other areas of their lives. For example, they might be employed or have appointments that keep them from attending weekly breakfast and the following activities. It is important to note that there were no differences between



PHOTO: ©ISTOCKPHOTO.COM/DENISE LAYTON

Parents are encouraged to say a clear good-bye to their children when leaving and to greet them warmly upon return.

the groups in their attendance at parent-child therapy sessions or separation practice. The clinicians are able to be more flexible in scheduling these sessions—offering to work around a parent's obligations in order to fit in several sessions during their time in the Nursery.

It is plausible that all three of these explanations contributed to the differences between the high- and low-scoring groups. Data on mothers' individual needs and obligations—such as their own stress, depression, or relationship needs as well as employment status and appointment schedule—would shed some light on whether these are factors in the differences between groups. The good news is that the staff successfully engaged the families with the most problematic parent-child relationships, and these families responded to the interventions. Typically, parents who could benefit most from interventions experience many barriers to obtaining treatment (as described by Kazdin, Holland, & Crowley, 1997). The Nursery program is structured to make it as accessible as possible in order to decrease barriers. The family ties breakfast draws parents in and then they are encouraged to stay. It is likely that the reason the breakfast and circle time have the highest attendance is because attachment-based circle time is held immediately following the breakfast. Some mothers may be unable or unwilling to stay for the more intimate interventions of parent-child activity and parent group.

In exploring the contribution of maternal participation to improvements in parent-child interaction, we must consider what

happens during the intervention. For example, during parent-child therapy sessions, mothers and clinicians watch the videotapes that are scored for the NCAST. There are two components to this—an opportunity for mothers to directly observe themselves in the parenting role plus feedback from a clinician. Both aspects likely contributed to the effectiveness of the intervention (Koniak-Griffin, Verzemnieks, & Cahill, 1992). Direct observation increases self-awareness (Crittenden & Snell, 1983). Clinicians coach mothers in specific behaviors such as positioning their children so that eye contact is possible, soothing their children when distressed, decreasing negative comments to children, and focusing their own and the children's attention on the task. These behaviors also earn higher parent-child interaction scores when displayed during their final videotaped session. Therefore we would expect that when parents engage in more therapy sessions, their scores would increase. The data support this and suggest that the clinicians are effectively helping parents to increase their positive parenting behaviors. It is especially encouraging that scores on the Contingency subscale score are improved for the low-scoring group, as this scale is a good measure of a mother's skill in recognizing and responding to her child's cues and also of her abilities supporting the children in displaying clear behavioral cues that communicate their needs.

During the parent group, mothers were able to focus on parenting and other aspects of their lives without the distraction of

Copyright 2010 ZERO TO THREE. All rights reserved. For permission to reprint, go to www.zerotothree.org/reprints rather than the stresses of living in poverty. Additional outcome measures, especially another measure of parenting behavior would be informative in determining whether the improved parenting behaviors generalize to other situations. Further, we know that many of the children in the Nursery show delays in development of language and play skills upon enrollment. Outcome measures in these areas could determine if increasing cognitive growth-fostering behaviors in parents has an effect on child developmental outcomes.

Another limitation is the inability to evaluate the long-term effects of the Nursery program. Families leave the Nursery after a few months, and although some are followed during a transition period, contact is lost with most families. Follow-up evaluations would determine whether the changes persisted over an extended time period and would also gain information regarding the effects of early intervention on later child outcomes. Finally, the sample size of this study does somewhat limit its generalizability. The differences in the low- and high-scoring parents forced a decision to conduct analyses using groups, thus decreasing sample size even further.

Although the scores of some parents did not change from pre- to post-intervention, even stable scores should be considered a measure of success. Unpublished data using the NCAST have shown that it is typical for parents in highly stressed situations such as homelessness to show declines in NCAST scores (K. Barnard, personal communication, May 2005). As such, scores that did not decline were seen as a positive response to intervention.

In interpreting these findings, consideration must be given to the limitations of the study, including the fact that it is a retrospective study of typical care, without research controls. A comparison group of low-income, poorly housed families would be helpful in determining whether the results are specific to homelessness

rather than the stresses of living in poverty. Additional outcome measures, especially another measure of parenting behavior would be informative in determining whether the improved parenting behaviors generalize to other situations. Further, we know that many of the children in the Nursery show delays in development of language and play skills upon enrollment. Outcome measures in these areas could determine if increasing cognitive growth-fostering behaviors in parents has an effect on child developmental outcomes.

Anecdotal, clinicians in the Nursery attribute changes to the interventions not just of parents but also of both clinical and child care staff. The guiding philosophy in the Nursery, along with being strength-focused and family-centered, includes the “continuum of nurturance” which is most credited by staff for the success of the interventions in the Nursery. This refers to an effort to provide nurturing support at every level: the funding agency and the YWCA support the administrators of the Nursery, the administrators nurture the clinical and child care staff, and the child care and clinical staff nurture the parents. The children receive the final benefit in this chain, in that parents, when their emotional needs are met, are more available to nurture their children. It may not be possible to measure the effects of this philosophy, other than the evidence that parents engage in the interventions and improve their parent-child interactions while in the Nursery. There is also very low staff turnover at the Nursery. The continuum of nurturance may play a part in retaining staff in what could be a high “burnout” position. The staff continuity allows for increased training and experience, which very likely contribute to the effectiveness of the program.

There is a need for continued research into parenting and homelessness, and program philosophy may play a part in future research. The current results should inform program development for young children and their parents who are experiencing homelessness. Video feedback is an effective individual

intervention, and the parent psychotherapy group offers an intervention for mothers while their children are being cared for. Mothers seem to enjoy the family meal time offered at the family ties breakfast, and this is a way to encourage them to stay for parent-child activities. These and other unmeasured variables contribute to improved parent-child interaction while in the Nursery, and, we hope, to increased resilience in the Nursery’s families. ¶

ALISON HEINHOLD MELLEY, PhD, has served as a research consultant at the Therapeutic Nursery, part of Kennedy Krieger Institute’s PACT: Helping Children With Special Needs program for the past 6 years. Dr. Melley was formerly a psychology intern at the University of Maryland School of Medicine, Taghi Modarressi Center for Infant Study.

KIM COSGROVE, LCSW-C, has worked for the past 20 years in home-based family therapy and child play therapy at the Kennedy Krieger Institute. For the past 11 years she has been the director of PACT’s Therapeutic Nursery and has been instrumental in developing an attachment based therapeutic child care and Early Head Start program for very young homeless children and their families. She has developed a number of trainings to address the challenges facing very young homeless children.

CAROLE NORRIS-SHORTLE, LCSW-C, is assistant clinical professor University of Maryland, certified NCAST instructor, registered play therapy supervisor, and licensed marriage and family therapist. She has done clinical work and training in the area of infant mental health for the last 25 years, and is currently focused on attachment in the PACT Therapeutic Nursery for homeless babies and their parents.

LAUREL J. KISER, PhD, MBA, is an associate professor in psychiatry at University of Maryland School of Medicine. She serves as a clinical supervisor at the Secure Starts Program in the Center for Infant Study and as a faculty member for the University of Maryland Baltimore Developmental Psychopathology Seminar and the Early Childhood Mental Health Certificate program. Dr. Kiser focuses on the impact of trauma on family systems.

ERIC B. LEVEY, MD, is the director of Philip A. Keilty Center for Spina Bifida & Related Conditions, Kennedy Krieger Institute and assistant professor of pediatrics, Johns Hopkins University School of Medicine. Dr. Levey is a medical provider for infants and children with birth defects and developmental disabilities and served on the steering committee for state Early Childhood Comprehensive Systems Change grant.

Learn More

PACT: HELPING CHILDREN WITH SPECIAL NEEDS

www.pact.kennedykrieger.org

PACT: Helping Children With Special Needs is a private, nonprofit organization, affiliated with Kennedy Krieger Institute in Baltimore, MD. PACT provides services to address the physical, cognitive, emotional, and social needs of children with special needs and to provide support for their families.

CIRCLE OF SECURITY

www.circleofsecurity.org

Circle of Security is an early intervention program for parents and children. The video-based intervention is based on attachment theory and research and is designed to improve parent-child relationships.

NATIONAL HEALTH CARE FOR THE HOMELESS

www.nhchc.org

NHCH is a membership organization involved in advocacy, research, and training for the needs and rights of the homeless.

CATHERINE A. COBLE, MSW, LCSW-C, is a clinical social worker at the Secure Starts Program at the Taghi Modarresi Center for Infant Study. She is also coordinator and faculty member for the University of Maryland Baltimore Early Childhood Mental Health Certificate Program, and an adjunct instructor for the UMB School Of Social Work.

AUDREY LEVITON, MSW, LCSW-C, is assistant vice president, Kennedy Krieger Institute; executive director, PACT: Helping Children With Special Needs. She has more than 27 years

of experience at Kennedy Krieger Institute and PACT: Helping Children With Special Needs providing a variety of programs for young children with medical, developmental, and emotional needs and their families.

Acknowledgments

We extend our thanks to the following organizations, without which our research and clinical work in the Nursery would not be possible: Baltimore

Mental Health Systems, Martin Luther King Early Head Start, YWCA of Central Maryland, Mercy's Children Health Outreach Program, Kennedy Krieger Institutes Child and Family Support Program, and Secure Starts: Center for Infant Studies, University of Maryland Medical System. We also extend our tremendous appreciation to the Therapeutic Nursery staff and families for participating in this project.

Correspondence concerning this paper should be directed to Alison H. Melley at amhzz@alumni.virginia.edu

References

- ADMINISTRATION FOR CHILDREN AND FAMILIES. (2002). *Making a difference in the lives of children and families: The impacts of Early Head Start programs on infants and toddlers and their families*. Washington, DC: U.S. Department of Health and Human Services.
- BASSUK, E. L., WEINREB, L. F., DAWSON, R., PERLOFF, J. N., & BUCKNER, J. C. (1997). Determinants of behavior in homeless and low-income housed preschool children. *Pediatrics*, 100, 92-100.
- BELL, S., & EYBERG, S. M. (2002). Parent-child interaction therapy. In L. VandeCreek, S. Knapp, & T. L. Jackson (Eds.), *Innovations in clinical practice: A source book* (Vol. 20; pp. 57-74). Sarasota, FL: Professional Resource Press.
- BRAITHWAITE, D. O., BAXTER, L. A., & HARPER, A. M. (1998). The role of rituals in the management of the dialectical tension of "old" and "new" in blended families. *Communication Studies*, 49(2), 101-120.
- CRITTENDEN, P. M., & SNELL, M. E., (1983). Intervention to improve mother-infant interaction and infant development. *Infant Mental Health Journal*, 4(1), 23-31.
- DAVENPORT, B. R., & BOURGEOIS, N. M., (2008). Play, aggression, the preschool child, and the family: A review of literature to guide empirically informed play therapy with aggressive preschool children. *International Journal of Play Therapy*, 17(1), 2-23.
- KAZDIN, A. E., HOLLAND, L., & CROWLEY, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology*, 65, 453-463.
- KELLY, J. F., BUEHLMAN, K., & CALDWELL, K. (2000). Training personnel to promote quality parent-child interaction in families who are homeless. *Topics in Early Childhood Special Education*, 20(3), 174-185.
- KISER, L. J. (2001). *Strengthening family traditions manual*. Unpublished manuscript.
- KONIAK-GRIFFIN, D., VERZEMNIEKS, I., & CAHILL, D. (1992). Using videotape instruction and feedback to improve adolescents' mothering behaviors. *Journal of Adolescent Health*, 13, 570-575.
- KOPLOW, L. (1996). Why homeless children can't sit still. In Koplow, L. (Ed.) *Unsmiling faces: How preschools can heal*. New York: Teachers College Press.
- MARKSON, S., & FIESE, B. H. (2000). Family rituals as a protective factor for children with asthma. *Journal of Pediatric Psychology*, 25(7), 471-479.
- NATIONAL ALLIANCE TO END HOMELESSNESS. (2007). *Fact checker: Family homelessness*. Washington DC: Author.
- NATIONAL RESEARCH COUNCIL & INSTITUTE OF MEDICINE. (2000). *From neurons to neighborhoods: The science of early childhood development*. J. P. Shonkoff & D. A. Phillips, (Eds), Board on Children, Youth, and Families; Commission on Behavioral and Social Sciences and Education. Washington, DC: National Academy Press.
- NORRIS-SHORTLE, C., MELLEY, A. H., KISER, L. J., LEVEY, E., COSGROVE, K., & LEVITON, A. (2006). Targeted interventions for homeless children at a therapeutic nursery. *Zero to Three*, 26(4), 49-55.
- PETTIT, G. S., BATES, J. E., & DODGE, K. A. (1997). Supportive parenting, ecological context, and children's adjustment: A seven-year longitudinal study. *Child Development*, 68, 908-923.
- PROULX, L. (2002). *Strengthening emotional ties through parent-child-dyad art therapy: Interventions with infants and preschoolers*. London: Jessica Kingsley Publishers
- RUBIN, K. H., BUKOWSKI, W., PARKER, J. G. (1998). Peer interactions, relationships and groups. In W. Damon & N. Eisenberg (Eds.) *Handbook of Child Psychology Vol 3: Social, emotional, and personality development* (5th ed.; pp. 619-700). New York: John Wiley & Sons.
- SCHAEFER, C. E. (1980). Play therapy. In G. P. Sholevar, R. M. Benson, & B. J. Binder (Eds.), *Emotional disorders in children and adolescents*. New York: Spectrum.
- SUMNER, G., & SPIETZ, A. (1994). *NCAST caregiver/parent-child interaction teaching manual*. Seattle: NCAST Publications, University of Washington, School of Nursing.
- VIERE, G. M. (2001). Examining family rituals. *Family Journal-Counseling & Therapy for Couples & Families*, 9(3), 285-288.