

Supporting Low Income Parents in the Early Years: Group and Dyadic Intervention Programs  
for Mothers and Babies

Eve Atkins

May 2021

---

Submitted in partial fulfillment  
of the requirements for the degree of  
Master of Arts in Child Development  
Sarah Lawrence College

Table of Contents

ABSTRACT..... 3

INTRODUCTION AND LITERATURE REVIEW..... 4

    Understanding Attachment Theory .....4

    Attachment Behaviors: Strange Situation..... 6

    Obstacles to Secure Attachment ..... 8

    Importance of Early Engagement between Parents and Babies..... 9

    Early Intervention Modalities ..... 12

    Parent-Infant Psychotherapy ..... 13

CLINICAL EXPERIENCE PART I: GROUP BASED WORK ..... 15

    Group Work: Bright Beginnings Expectant Mothers and Bright Beginnings Parent and Baby Year One ..... 16

    Understanding the Participants ..... 18

    Challenges of Group-Based Work..... 19

    Bright Beginnings Parent and Baby Year One Group ..... 22

CLINICAL EXPERIENCE PART II: DYADIC COACHING ..... 27

    Background/Development of Dyadic Coaching..... 27

    Curriculum Development/Important Themes ..... 29

    Case Studies ..... 29

        Case One- Evette and Hudson

        Case Two- Robin and Mia

        Case Three- Grace and April

    Reflections and Observations from the Sessions ..... 55

CONCLUSION ..... 58

REFERENCES..... 60

### **Abstract**

The study of infant mental health has developed significantly over the last three decades. Now there is greater knowledge that the early years of life are vital for social and emotional development across the lifespan (Brazelton, 1990; Zeanah et al, 2000). It has become widely accepted that the parent child bond is now understood to be highly predictive for healthy childhood development. So, as a result, it is critical to understand the development of Attachment Theory, and the ways in which it has guided our foundational knowledge of the importance of the early years, and the interactions between caregivers and infants. For some parents, forming a secure attachment with their infant proves difficult. Early intervention programs in both group and individual dyadic settings can help to promote healthy attachment between caregiver and infant. My social work internship placement provided me with an opportunity to explore attachment work in the context of group work as well as infant-dyadic coaching. I also had the opportunity to design and carry out some coaching with individual mother and baby pairs. This thesis will address forms of promoting healthy attachment between caregiver and infant in both group and individual dyadic settings. A prenatal and parent and baby group will be discussed to highlight group work interventions. Three case studies from my internship at Henry Street Settlement Parent Center will be used to illustrate a dyadic intervention model.

## **INTRODUCTION AND LITERATURE REVIEW**

This section will first discuss what we have learned from attachment theory about forming a secure base in the early years. Then I will consider early intervention modalities and the parent infant program in which I participated as a social work student intern. There is a great deal of research showing the profound impact of early caregiving experiences on a child's early and later social, emotional, behavioral, and cognitive development (Holland, 2008). Infancy is a critical developmental period of significant and rapid brain growth with a great amount of environmental influence. During this time, core neurodevelopmental capacities grow that pave the way for psychological and emotional wellbeing later in life. Promoting attachment and infant mental health is essential in the early years because the quality of the caregiver and infant relationships shape psychological, neurological, and social development (Zeanah et al, 2000).) A healthy attachment between caregiver and infant may be more difficult to achieve for individuals who experience poverty, addiction, child removals, single parenting, traumas, or other significant stressors. This thesis will consider two intervention models: group work with parents and infants and individual mother and infant coaching.

### **Understanding Attachment Theory**

Attachment theory is one of the most empirically grounded theories relating to parenting. Attachment is one particular aspect of the relationship between a child and caregiver that is involved in making the child feel safe, secure, and protected (Ainsworth, 1964). It is an emotional bond that infants develop with their caregiver during the first year of life and refers to the relationship that emerges overtime from a history of caregiver-infant interactions. Attachment Theory originates primarily from the work of John Bowlby and Mary Ainsworth in the 20<sup>th</sup> century (Ainsworth, 1964).

Bowlby, a psychiatrist became interested in human attachment as a result of both his clinical observations of disturbed children who were deprived of their mothers in childhood and animal models. Bowlby revolutionized the way we look at attachment because he recognized that environmental factors greatly impact caregiver behaviors (Cassidy et al., 2013). He understood that a child's development was impacted by parental response throughout their childhood. His theory suggests that attachment plays a critical role in survival, therefore through evolution children have become biologically pre-programmed to form attachments to their caregiver. Bowlby recognized "attachment behaviors" for example, the social smile, which he suggested helps infants ensure physical proximity to their caregiver (World Health Organization, 2004). Around six weeks old, infants begin smiling. This form of attachment behavior serves to elicit a response from the caregiver and engage the infant. Bowlby's contribution to attachment theory includes four phases of attachment that children undergo: indiscriminating social responsiveness (0-3 months), preferential social responsiveness (3-6 months), the emergence of secure-base behavior (6-24 months) and goal corrected partnership (24-30+ months) (Bowlby, 1979).

During the indiscriminating social responsiveness phase, infants do not have a preference for one person over another person. Bowlby understood this to change in the second phase, preferential social responsiveness phase, where infants become more selective in their social responses. Typically, infants in this phase will smile only at familiar faces and begin favoring individuals who have cared for them (Bowlby, 1979).

At around six months, infants enter what Bowlby labeled as the emergence of secure-base behavior. This phase is marked by an intensity in caregiver and infant attachment and is often when separation anxiety and stranger fear develops. As infants learn to crawl, typically in this phase, they develop an ability to access their caregiver when they choose by crawling to them

and maintaining proximity. Crawling allows the infant to explore the world in new ways. For infants who have formed secure attachments, they use the caregiver as a secure base to explore the world and develop other relationships (Bowlby, 1979). By the age of one, infants typically have established an internal working model of their attachment figure. In essence, they have built an internal representation of their primary caregiver through repeated responsiveness (Murphy et al., 2015). Alternatively, when a child is separated from their primary caregiver either temporarily or for a long time, the child loses their internal sense of security. An infant's internal working models of expectations about the self, others, and relationships can be impacted over time by the departure and reunion of a caregiver (Murphy et al., 2015).

Phase four of attachment, goal corrected partnership begins around three years old and marks a shift in the toddler's primary focus of maintaining proximity to their attachment figure. Instead, toddlers in this phase begin to be able to think about goals and plans of their caregiver, understand that their caregiver is still there even when not physically present, and separate more easily (Murphy et al., 2015).

### **Attachment Behaviors: Strange Situation**

Mary Ainsworth expanded on Bowlby's theory of attachment and sought to understand different attachment behaviors that could develop between infants and caregivers. Ainsworth defined attachment behaviors as, "behavior through which a discriminating, differential, affectional relationship is established with a person or object, and thus initiates a chain of interaction which serves to consolidate the affectional relationship" (Ainsworth, 1964, p51).

Ainsworth is most well known for her study of the "Strange Situation" where researchers observed children who were 12-18 months old as they respond to a situation in which they were briefly left alone and then reunited with their mothers. At first, a stranger enters the playroom

while the mother is still present, and then the mother leaves, leaving the baby alone with an unfamiliar graduate student. After three minutes, the mother returns and the graduate student leaves. After the mother has engaged with the child, she was instructed to leave again, this time leaving just the child in the room. Ainsworth wanted to see if the original distress was due to the child being left alone or because of the separation from mother (Ainsworth, 1970). Finally, the graduate student entered the room followed by the mother. Ainsworth concluded that the responses from the babies in this experiment mimic the real-life responses of infants when placed in “strange situations” or when they are fearful (Ainsworth, 1970). From this study, three patterns of attachment emerged: the ‘securely attached’ infant, the ‘insecure-avoidant’ infant, and the ‘insecure-ambivalent’ infant (Ainsworth, 1970).

Identified as the most positive form of attachment, securely attached infants used their mother as a secure base to explore their environment and as their attachment figure in times of distress (Ainsworth, 1970). These infants expressed distress when their attachment figure left but were able to be soothed by both the graduate student and eventually the mother upon their return. The infant sought proximity to the mother after coming back. For securely attached infants, there is an expectation of responsiveness because their mother has always responded to their needs.

Insecure-avoidant infants sought out exploration in the playroom, for example with toys, but appeared to ignore their mother and not use them as secure-bases. These infants were not in distress when their mother left and also did not seek proximity to them upon return. With insecure avoidant infants, they would turn their bodies or avoid their mother suggesting independence both physically and emotionally from their attachment figure (Ainsworth, 1970).

In contrast, insecure-ambivalent infants rarely left their mothers’ side after entering the playroom, failing to explore the toys, and appeared to be in extreme distress when their mother

did leave. Interestingly, when their mothers did return the infants showed a lot of ambivalence, clinging and sometimes even pushing the caregiver away. Ainsworth theorized that infants who fell into the insecure-ambivalent style had mothers who inconsistently met their needs and therefore the infants felt as though they could not rely on their mothers (Ainsworth, 1970).

Years later, Mary Main created a fourth category known as “disorganized attachment” because there were some infants who did not fall into the previous three categories. During separations and reunions, infants in this category displayed erratic behavior. Some exhibited fear, as a result of their caregivers display of aggression while others froze or acted disoriented because they perceived their caregiver to be frightened (Fonagy, 2004). Main understood that the behaviors displayed by these infants suggest a conflict between wanting their mother while also wanting to avoid their mother which ultimately resulted in the infant acting erratically (Fonagy, 2004).

### **Obstacles to Secure Attachment**

For parents who experience parent-child separations, poverty, pervasive mental illness, addiction, single parenting, or other significant stressors, promoting healthy attachment between caregiver and infant is especially challenging (Guo & Harris, 2000). Strong associations between infant attachment and later emotional and behavioral problems have been found for infants who were exposed to multiple stressors in the context of the family environment such as poverty or parental psychopathology. One longitudinal study looked at the development of children in a high-risk sample of young, single mothers, and found that insecure attachment at twelve and eighteen months increased the risk of emotional and behavioral problems for preschoolers up to adolescence (DeKlyen & Greenberg, 2008). Additional research suggests that differences in wealth are connected to health and well-being disparities in children (Guo & Harris, 2000).

Often harsher parenting conditions exist for families who grow up in poverty as a result of compounding stressors that promote insecure attachments in parent-child relationships (Guo & Harris, 2000). These parenting conditions are often replicated by later generations and thus the cycle of intergenerational poverty continues.

In addition to poverty, addiction is another area of significant stress that impacts both the caregiver and infant relationship. One article by Finger et al., (2017) looked at parenting contributors to early emerging problem behavior in children of mothers in methadone maintenance treatment. The study explored whether variations in parenting provided by mothers with substance-abuse disorders were related to behavior problems in young children. Additionally, they looked at whether specific parenting practices were associated with specific types of behavior problems. The research was conducted using self-report (mother-reported observational assessments). They found that mother-reported child externalizing behavior such as aggression was related to greater maternal harshness and mother history of illicit drug use during pregnancy but not to other features of substance use and treatment history. Additionally, observer-coded child internalizing behavior such as stress was related to less maternal sensitivity and less provision of learning activities in the home (Finger et al., 2017). The findings suggest that women in substance abuse treatment would benefit from receiving parenting instruction and that interventions should focus on increasing maternal sensitivity, reducing harshness, and providing children with cognitively stimulating environments.

### **The Importance of Early Engagement Between Parents and Babies**

In 1994, the Advisory Committee on Families with Infants and Toddlers developed the guiding principles for Early Head Start. The Committee's report emphasized that the young child cannot survive, let alone thrive without the nurturance, protection, and regulation provided by the

caregiving environment (Advisory Committee, 1994). The Advisory Committee described how caregiving relationships contribute to infants' and toddlers' emotional and psychological health:

*Within the context of caregiving relationships, the infant builds a sense of what feels right in the world, as well as skills and incentives for social turn-taking, reciprocity, and cooperation ... During the toddler period, the child, through repeated interactions with emotionally available caregivers, also begins to learn basic skills and self-control, emotional regulation, and negotiation. Empathy for others and prosocial tendencies for caring and helping also develop during toddlerhood, as well as the emotions of pride and shame; experiencing and learning about these capacities require responsive caregiving in the midst of life's inevitable stresses and challenges . . . A sense of pleasure, interest and exploration, early imaginative capacities, and the sharing of positive emotions also begin in infancy - all of which require repeated and consistent caregiver relationship experiences and form a basis for social competence that carries through toddlerhood and the preschool period ... (Advisory Committee, 1994).*

In addition to emphasizing the emotional and psychological health of an infant, understanding brain development both prenatally and postnatally is also important. It is critical to understand the development of an infant's brain and both experiences and circumstances that hinder "normal" brain maturity. Infancy is a critical developmental period of significant and rapid brain growth with a great amount of environmental influence.

Brain development begins a few weeks after conception, and by the time a full-term baby is born, their brain is about one-third the size of an adult's (Holland, 2008). Luby notes, "in the early postnatal period, glial proliferation, axonal formation, and dendritic arborization result in dramatic increases in brain volume and cortical surface area. Additionally, synaptic pruning acts to regulate these processes" (2017, p 74). While this is taking place, myelination is also happening, but at a much slower rate. Luby also notes, "myelination results in an increase in white matter volume and a maturation of microstructural integrity" (2017, p 78).

In the first year of life alone, the volume of the cortex nearly doubles. Additionally, within the first ninety days alone, the cerebellum doubles in size (Holland, 2008). Babies' brains are wired for learning at birth, but how a newborn learns to interact with the world depends

heavily on early interactions with parents and caregivers, particularly during the first three years of life, which is also the critical period of brain development (Luby, 2017). During the first year alone, 700 neural connections form per second, and they are direct responses to a baby's environment and experiences. While these biological processes are critical to an infant's ability to adapt to his or her environment, the features of that environment are critical as well. These early neural connections form the basis for how we think, learn, feel, and form relationships (Altman, 2010). Babies who have positive, loving interactions will learn to expect love and security from the world, while those who experience chronic stress or neglect will learn the world is not a safe or supportive place (Greenspan, 2006).

Creating positive experiences can be as simple as engaging with your child in a loving way. It is learning to recognize verbal and nonverbal cues and responding to individual needs as well as talking to your child throughout the day, playing with them, showing affection, and engaging in a type of interaction known as serve and return. Serve and return involves back and forth. Think playing peekaboo, throwing a ball, or allowing your baby to respond when you talk to them (smiling, babbling, and cooing) (Gil, 2017).

Touch is another important aspect of an infant's environment. Touch and other non-verbal interactions are essential areas for infant engagement. Touch is the human infant's first learning modality, shaping experiences even during the prenatal period (Mori & Kuniyoshi, 2010). An infant's tactile sense is the most advanced sense at birth and development begins in the first gestational week. Touch is extremely important as it underlies the organism's growing awareness of itself and the environment (Mori & Kuniyoshi, 2010). Without receptive and active touch experience, an infant cannot develop adequately (Barlow, 2009).

## **Early Intervention Modalities**

Studies on early intervention for caregivers and infants who have been identified as having significant stressors show the impact that healthy infant/caregiver attachment has and the better long-term outcomes (Holland, 2008). There are a variety of interventions addressing the emotional and social developmental need of infants, including infants and parents in an individual or group setting, on a short-term or long-term basis, using psychodynamic or behavioral approaches (Zeanah, 2005). Many of these psychotherapies are relationship-based to acknowledge the development of a child occurs in the context of past and present relationships.

Given that there is such a wide variety of needs when working with caregivers and infants, and providers vary in the types of interventions they offer a continuum of infant mental health services is necessary (Zeanah et al, 2000). Currently, there are many different modes of deliveries including intervention site (e.g., clinic, home, child-care setting), provider (e.g., mental health clinician, nurse, paraprofessional), and finally, the severity of the problem (e.g., no problem/prevention, parenting or family problems, severe child behavior/emotional problems) (Zeanah et al., 2000).

Zeanah et al., note that, “the common goal is to enhance the ability of caregivers to nurture young children more effectively; to expand the ability of non-family caregivers to identify, address, and prevent social-emotional problems in early childhood; and to minimize or avert suffering, and ensure that families in need of more intensive services can obtain them” (2000, p 11). The key to this intervention is the caregiver-infant relationship (Barlow, 2009). This differs from the traditional approach of focusing specifically on the child or caregiver.

## Parent-Infant Psychotherapy

Parent-Infant psychotherapy is a dyadic intervention treating parents and their infant together. This model targets the parent-infant relationship and promotes infant attachment and infant development and targets disturbances within the caregiving, baby, or interactional context i.e., peri-partum depression, breastfeeding and sleep challenges, infant distress, and attachment disorders. This psychotherapy works to improve the parent-infant relationship directly by understanding the parent's view of the infant, which may be affected by their own experiences, and links them to their current relationship with the child (Barlow et al., 2015). This intervention model, introduced by Selma Fraiberg is rooted in attachment theory and psychoanalysis (Salomonsson, 2014). Fraiberg was an early framer of parent-infant psychotherapy.

Fraiberg emphasized the importance of a therapeutic environment for parents to be able to learn how to parent. While there are biological and hormonal impulses that promote attachment, most of what we know as parenting is learned most commonly from our own parents or caregivers. It is important to help caregivers to understand the importance of interactions in the early years of their child's development so that self-growth, and awareness can be fostered.

However, even so, our past affects the present, for better and for worse. Fraiberg's (1975) "*Ghosts in the Nursery*", dramatically describes how babies' environments are always filled with the memories of their parents' own pasts-- some nurseries are riddled with many "ghosts"- artifacts of parents' traumatic histories. The ghosts that Fraiberg refers to are the kind that are unseen, sometimes tormented, and tormenting. They do not have voice, or body, or substance, but they have impact. They often manifest as symptoms, deep emotional wounds, and broken relationships. Sometimes, the symptoms and problems are experienced immediately in the form of children acting out, or tension in the home. Other times, these symptoms come out

only years later in the form of a relentless depression, anxiety, eating disorder through adulthood. These ghosts come from many places often transcending across many generations. They represent the voices of the past. These ghosts cross all socio-economic backgrounds, education levels, and races. According to Fraiberg, they are often the abusive voices. The father's voice who abandoned the family; the mother's who favored the first born and neglected the others; the parents who wanted to control too much too often. Theirs are the voices of ghosts that linger, and haunt, and continue the intergenerational transmission of past trauma. Fraiberg highlights the importance of remembering the pain (Fraiberg, 1975). Parenthood offers many challenges, and those with "ghosts from the past" can especially benefit from early intervention work with their infant. Fraiberg noted three intervention modes: brief crisis interventions, interaction guidance-supportive treatments, and infant-parent psychotherapy (Salomonsson, 2014).

## **CLINICAL EXPERIENCE PART I: GROUP BASED WORK**

My clinical internship as a social work intern took place at Henry Street Settlement. Henry Street Settlement has a long history serving the Lower East Side and surrounding areas for over 100 years. Henry Street was founded by Lillian Wald, a humanitarian, nurse, and progressive reformer in 1893 and provides social services, arts programs, and health care services to individuals all across New York City. My internship was at The Parent Center which is just one of the many programs that Henry Street offers. Other programs at Henry Street Settlement are housing/shelters, senior programs, youth programs, workforce development center, health and wellness services, benefits screening and legal counseling center, and an arts center (Henry Street, 2019).

Henry Street Parent Center is located on the Lower East Side; however, people come from all of the five boroughs: Manhattan, Brooklyn, Queens, The Bronx, and Staten Island. The clients served are parents and children. Many of the parents have involvement with Administration for Children's Services (ACS) and are mandated to complete parenting classes, although that was not the case for all of the parents I worked with as some were self-enrolled.

The client population mostly consists of lower-income parents and children, single parents, many of whom are Black and Latinx. Some of the clients are not citizens of the United States. The Parent Center is entirely privately funded. They have no government or insurance contracts, and thus they are beholden to no one but the community they serve and their private funders. The Parent Center offers free workshops and programs designed to "help negotiate the challenges and celebrate the joys of raising children. The Parent Center takes a holistic life-balance approach that focuses on the roles of father, mother, grandparents, and family. Staff is trained in health, behavioral health, life-span development and wellness, and in addressing

cultural influences on parenting styles” (Henry Street, 2019). Referrals typically come from foster care agencies, treatment facilities, and hospitals.

My initial role was to co-facilitate groups at The Parent Center, conduct intakes, and co-lead workshops. At the Parent Center, it is preferable to have two facilitators for any given group work in order to address a range of different challenges that can surface during a group. In addition to group facilitating, I also engaged in individual parent and infant dyadic coaching which will be discussed in the section titled: Clinical Experience Part II.

### **Group Work: Bright Beginnings Expectant Mothers and Bright Beginnings Parent and Baby Year One**

While I co-facilitated many different groups, the focus of this section will be on two different parenting group classes: Bright Beginnings Expectant Mothers and Bright Beginnings Parent and Baby Year One (2-12months). The Bright Beginnings Parent and Baby Year One group will be explored in depth to provide insight about some of the challenges of raising an infant with significant life stressors. Both of these community-based prevention programs followed The Ackerman manualized curriculum (Edwards, 2014).

The Bright Beginnings Curriculum was developed by Martha Edwards, the founder, and director of the Ackerman Institute’s Center for the Developing Child and Family. It is a longitudinal prevention program for infants, toddlers, and their families. The program was created for individuals transitioning to parenthood and was designed to promote infant mental health, school readiness, and the ongoing relational development of children and parents (Edwards, 2014). The program is divided into four different groups.

The first group, Bright Beginnings Expectant Mothers, was a prenatal group consisting of six weekly sessions. After the prenatal group there was Bright Beginnings Parent and Baby Year

One (0-12 months) twelve-week group, followed by two toddler groups, Bright Beginning Parent and Toddler Year Two (13-24 months), and Bright Beginnings Parent and Toddler Year Three (25-36 months). All of the groups met weekly for an hour and a half. Each group had a video review component and a home visiting component, although The Parent Center engaged in only the group component. The Parent Center adapted the twelve-week Bright Beginnings curriculum to a six-week session. The prenatal group and Parent and Baby Year One group will be the focus of this section. The Parent Center operated on a six-twelve week group calendar model, so throughout my yearlong internship, I co-facilitated each of the groups a few times. This section will focus on my second round of facilitation with Bright Beginnings Expectant Mothers and Bright Beginnings Year One.

The first group, a six-week Expectant Mothers group was designed to help pregnant mothers become attuned to their bodies and emotions, develop a bond with their unborn child, and promote support between women in the same stage of life (Henry Street, 2019). Each session was structured around a theme such as the story of the pregnancy, physical changes; feelings about the pregnancy, getting to know your baby, reactions to your pregnancy, and social support (Edwards, 2014).

The second group, Bright Beginnings Mother and Baby was a six-week group and aimed to familiarize new parents with the developmental needs of their baby, teach methods for fostering attachment, and develop communication, socialization, and sensory-motor skills (Henry Street, 2019). The participants in the Bright Beginnings Mother and Baby group differed from the participants in the prenatal group. Each week centered on a topic/theme and included group discussions and application of the ideas to parent-child interactive activities (Edwards, 2014).

## **Understanding the Participants**

It is critical to understand the population, cultural background, and group dynamics that existed within the Bright Beginnings Parent and Baby Year One group. Names and other identifying information have been changed to ensure confidentiality. Many referrals and clients came from a methadone maintenance program located near The Parent Center which allowed some mothers to be treated for opioid addiction while still retaining custody of their infants.

The Expectant Mothers group consisted of three Caucasian women who lived in the same methadone maintenance facility. Melony had two other children who were given up for adoption and a two-month-old infant who was still in the NICU. Melony was mandated to attend parenting classes because of ACS involvement. Christine was a first-time mother and had a three-month old infant and was also mandated to attend group due to ACS involvement. Anna was a first-time mother with a six-month old infant and was recommended by her caseworker to attend the group, but was not mandated. All three of these women were long time substance users and had little financial or family support. This facility supported, housed, and medicated women who were going through opioid addiction treatment. Childcare services were provided to clients while they engaged in methadone treatment, therapy, group work, and doctors' appointments. Clients were carefully monitored and were expected to follow strict protocol to keep their infants with them. These three mothers faced obstacles to parenting an infant while also being addicted to drugs themselves. As a result of the strict protocol the mothers faced, the infants had limited exposure to the outside environment.

In addition to those three group members, there was a seventeen-year-old Hispanic woman named Isabelle with a three-month old and a twenty-seven-year-old and an African American woman named Amber with an eight-month-old, both of whom grew up in the foster care system

and became pregnant unexpectedly. Isabelle was recommended by her school counselor to attend a parenting group and Amber was mandated to attend the group after involvement with ACS. Both women lived below the poverty line. Another expectant mother, a thirty-one-year-old upper-middle class Chinese American woman, Ali, did not return after the first session. Ali heard about The Parent Center through word of mouth and had no experience with the foster care system and was not struggling with addiction. From intakes completed before group, I knew that all five of the other women came from low-income backgrounds with no more than a high school diploma and many had ACS involvement.

### **Challenges of Group-Based Work**

The atmosphere was designed to be warm and welcoming. My co-facilitator and supervisor was a Licensed Clinical Social Worker (LCSW). Due to my background in child development, she asked if I would take the lead. The co-facilitator and I introduced ourselves to the group, explained our roles as facilitators and our role as either a social worker or the social work intern. After one of the group members Ali dropped out, I began thinking about the impact of culture, socioeconomic class, upbringings, and lived experience on different parenting ethnotheories (cultural beliefs), behaviors, parent readiness, and growth potential for the parent-child attachment relationship in relation to group work. Parental ethnotheories reflect the cultural belief system that parents hold with regard to the nature of children, development, parenting, and the family and informs differing childrearing values (Harkness & Super, 1966). Poverty, one factor that all five of the group members experienced, both directly and indirectly impacted their view on parenting.

Poverty or economic pressures impact the emotional lives and daily interactions of adults but then diffuse into the caretaking environment of the child. Poor families, as with all five of the

participants in group, often confront multiple stressors, such as structural racism, overt racism, unemployment, substance abuse, substandard housing conditions, and lack of health insurance resulting in substandard medical treatment. All of these significant factors perpetuate the intergenerational cycle of poverty and make it more challenging for a parent and infant to develop a secure attachment (Brown, 2008).

While the Bright Beginnings group aimed to strengthen the caregiver-infant relationship, we must first understand the systemic barriers that plagued the group members and challenged secure caregiver-infant attachment. This model helped to ensure that we incorporated different perspectives that valued the voices of the marginalized individuals. A purposeful effort was placed on facilitating the group using a multicultural and culturally competent perspective in relation to group cohesion and group dynamics (Walsh, 2013). Using a multicultural perspective increases knowledge, awareness, and understanding about race, ethnicity, gender, and immigrant populations (Walsh, 2013). Social work emphasizes the value of practicing using a culturally competent lens that seeks to understand, value, and respect cultural differences among clients, practitioners, or facilitators (Walsh, 2013). We created space for the clients and facilitators to discuss the impact of culture on different parenting styles, beliefs, and practices in a way that valued and embraced different perspectives. In doing so, I must also acknowledge the privilege and power that comes with my position as a facilitator and a white woman.

I reflected on my role as a facilitator and the impact that my race, education, age, and cultural background had on the group dynamics. In previous groups at The Parent Center, I did not mention that I did not have any children unless directly asked because I feared this detail would undermine my credibility as an “expert” on parenting and child development. However, this led to me feeling inauthentic in past groups. Instead, I challenged myself to be more forthcoming

and understood that the question was not rooted in judgment but instead curiosity. Questioning someone is one way of better understanding them. After I opened up, others did as well, and it created a context in which sharing was encouraged.

While fostering positive facilitator and group alliance was important, I also shaped the curriculum slightly to include conversations around attachment, bonding, social interaction, and infant care in a way that felt sensitive and attentive to concerns and experiences of the members. As a group we discussed the importance of infant socialization and brainstormed together why it might be important for infants to have exposure to one another. The topic of socio-emotional development for infants was targeted to acknowledge the challenges of raising a baby in a treatment facility but was not limited to just the three group members in treatment.

Self-care was another topic that I brought into the curriculum. Three of the mothers in treatment expressed that they felt like their body had failed them for years by allowing them to inundate their bodies with addictive and destructive drugs. They discussed this transition from a body that failed them, to a body that could carry and create life. For months before their infants were born, they focused on staying clean, caring for their body, and their mind. They expressed worry about feeling overwhelmed with motherhood and how they would cope with stress while acknowledging the fear of reverting back to their old ways of using drugs. While this worry originated from only three of the mothers, all five of the members echoed trepidation around self-care and caring for an infant with little time to themselves. They supported one another offering different strategies that helped them during the first months of motherhood.

Conversations like these highlighted the benefit of a group model and its ability to support women across different life experiences, cultures, and upbringings.

### **Bright Beginnings Parent and Baby Year One Group**

The curriculum was formatted to be facilitated using direct, structured, and mildly prescriptive techniques such as interactive methods like reading to your baby (Edwards, 2014). Each session began with free play followed by an opening/welcoming song, check-in, and then group discussion. Free play was a central component of group, serving as a time to not only observe parents' interactions with their infants but also allowing the infants to get situated in their environment. If the infant was able to get acclimated to the new environment, they were often less distressed and therefore less demanding of the mother's attention during group. This allowed for more discussion time amongst the mothers (Edwards, 2011, Year 1, Session 1). Blankets and soft mats were dispersed throughout the room. Infants, mothers, and the facilitators sat on the floor. The opening/welcoming song encouraged a sense of community and assisted in learning the name of the mothers and infants. A check-in was a critical component of this curriculum because it created space for parents to share how they were doing and feeling before engaging in the material for that session. Facilitators were encouraged to refer to ideas and techniques from previous weeks as a "check-in" and means for group discussion and questions (Edwards, 2011).

There were twelve themes discussed in Bright Beginning's Year One Curriculum, however, the group ran for only six weeks. The Parent Center did not use the video component of the Ackerman curriculum which allowed us to merge two weeks of the curriculum into one group.

Session one titled: "Getting to Know One Another" was designed to help group members and facilitators to familiarize and introduce themselves and their infants. Questions were asked such as, "How did you name your baby?" and "What songs do you sing at home?". The group also

discussed what a letter written from an infant's perspective to his/her parent might be and parents' goals for participating in the Bright Beginnings Parent-Child Program. Additionally, an overview of the Bright Beginnings Parent and Baby group from Edwards (2011) was explained:

Bright Beginnings is a socialization program for infants and their caregivers. Parenting is both challenging and very rewarding, so this group is an opportunity to gain support while helping your child to grow and develop. The goal is for caregivers to come together to share information and experiences, learn together, and support one another. The infants always come first, so do not hesitate to take care of their needs even if it disrupts the group.

Group rules, guidelines, and confidentiality parameters were created during the first session to promote the feeling of safety and security among group members.

The next segment titled "Learning About the World" focused on the seven senses: hearing, touching, tasting, seeing, smelling, proprioception (position), and vestibular system (motion). This topic aimed to help the mothers become more aware of the way infants use their senses to explore the world at different developmental ages (Edwards, 2011). Parents discussed different activities their infants engaged in and learned from others new ways to support their infant's interests and ways to soothe them when upset. Having the infants in the group allowed us as the facilitators to guide, demonstrate, and highlight different techniques throughout the session.

Session two, "The Give and Take of Communication" emphasized the importance of the parent-child relationship and talking to infants. Facilitators and parents discussed how infants communicate and how parents can "read" their babies' cues and respond in accordance with their

child's vocalizations (Edwards, 2011). Crying was a focus for the session, leading to discussions about reasons infants cry, parental reactions to crying, and how to soothe an infant in distress.

Session three, "Playing is Learning and The 'I can do it!' Feeling" focused on different aspects of play such as what play means, how infants play, and ways to engage in play with your infant. Different modes of play were demonstrated and illustrated using the infants as an instrument and tool. The next part of the session centered on the feeling of confidence and competency – in both parenthood and infancy. This section was broken into two components of the "I can do it!" feeling: 1. What the baby was doing, and 2. Sharing the good feelings that came with being able to do something with significant adults in his/her life. There were discussions centered around following the infant's lead and helping each mother to identify their parenting strengths.

Session four continued with the previous discussion around playing as a means for learning. Facilitators introduced a technique called the WAIT steps: Wait and watch, Attune to the child's feelings and acknowledge actions, Interact and enjoy, and Teach something new (Edwards, 2011). After discussing the WAIT steps, facilitators introduced the topic: Goals for Our Children. The mothers were asked to identify the characteristics they wanted their infants to develop, discuss ways to cultivate such traits and identify parenting goals. The purpose of this activity was to link the goals the mothers mentioned with practices and activities offered and discussed in previous weeks (Edwards, 2011).

Session five, "Learning to Talk" focused on responding to an infant's communication efforts. Facilitators assisted parents in promoting the use of language through gestures or vocalizations (Edwards, 2011). The curriculum used direct techniques to concretely provide

strategies for the mothers to help their children learn to talk such as: 1. Notice what the child is paying attention to and label those objects/properties of the objects, 2. Notice the child's attempts to communicate. Responding helps strengthen his/her understanding of talking and motivation to talk to you, 3. Talk about what you are doing together or what is going to happen next, and 4. Explore a book together (Edwards, 2011). One participant, Melony whose daughter was still in the NICU expressed concern about not being with her daughter all of the time and worried about her development. This led to a meaningful discussion around adapting the curriculum to work within certain limitations and constraints. For Melony, she was not able to be with her daughter all of the time but when she was with her, she could incorporate many of the techniques discussed. Being in a group with other mothers who did have their infants with them was a challenge that resurfaced in many conversations. This conversation led us into the next discussion around routines and the importance of a routine for the infant as well as the caregiver. Parents were asked to identify routines already in place, whether big or small, and if necessary, ways to gently guide or transition their infant into new or unfamiliar situations (Edwards, 2011).

In the sixth and final session "Guidance", facilitators presented methods of using routines, showing, acknowledging good behavior, and redirecting behavior. The mothers discussed their beliefs around what was acceptable and unacceptable for their children to do and how to guide and respond to the behaviors accordingly (Edwards, 2011). The final topic, "Putting it Together", asked the mothers to fill out a questionnaire reflecting on their experience in group and changes/suggestions as well as improvements they would like to see. Time for closing thoughts, questions, or feelings created a sense of closure. The group concluded with another letter, similar to the one read during week one titled "Letter from Your Child". The letter reflected what the child may be thinking, feeling, and doing as a seven- to ten-month-old. The

letter foreshadowed later development and encouraged the mothers to reflect on past and current development and milestones socially and emotionally (Edwards, 2011).

The Bright Beginnings curriculum emphasized the importance of caregiver-infant relationships while creating space for mothers to support one other. Building in time for discussions helped the mothers to connect and learn from each other. However, one of the challenges was the broad age range of the infants. On the one hand it was nice for the mothers to see infants at different developmental stages, but it was challenging to discuss how to care for infants at different stages because their needs change. For example, Amber, who had an eight-month-old at the start of group had many questions about feeding her son solid food. Many of the other women had infants that were around three or four months old, so the conversation was less relevant to where they were with their infant. If I were to co-facilitate the group again, I would suggest that we organize the group by age and create a newborn to four-month group and separate four-to-twelve-month group. With any group, you need to adapt the curriculum to meet the needs of the clients, but I found that I was able to adjust wording, phrasing, and topics to be culturally and environmentally sensitive. Overall, this curriculum seemed to balance important areas such as infant development, caregiver support, and maternal self-care well using engaging methods that fostered discussion and observation.

## CLINICAL EXPERIENCE PART II: DYADIC COACHING

### Background/Development of Dyadic Coaching

After interning at The Parent Center for a few months, I wanted to explore the possibility of melding both social work and my interest/degree in Child Development into a more individualized experience for clients. While we offered groups for infants and parents, we did not offer one-on-one sessions to discuss topics of interest or concern that were initiated by the parent. For this reason, it felt important to pursue individual services that could be offered to parents and their infant/toddler. I discussed with my supervisor, the possibility of working in a dyad with a parent and baby/toddler for a set of sessions. My supervisor was open to this potential programming, so I began thinking about how I wanted to structure this infant/toddler and parent work, how it would differ from the group work with parents and babies/toddlers already offered at the agency, and how to meet the needs of the individual pairs (parent and baby) every week.

I started making a handout to distribute to clinicians and agencies including The Administration for Children's Services (ACS). When conceptualizing this project, I gave careful consideration to how to best reach clients, clinicians, and other agencies to inform them of this new program being offered. For the group programs, a lot of the client base came from referrals from outside agencies such as ACS. In those cases, some clients were mandated to participate in parenting groups in an effort to show the court that they were actively engaging in bettering their parenting and should have their children return to the home. The groups that already existed were evidence-based, some were family court-approved, and followed a more prescribed set of sessions/topics each week.

In contrast, the program I developed would be offered to parents of infants/toddlers in a more individualized setting for up to one hour a week for a total of six sessions per family. This allowed me a great deal of autonomy and the ability to adapt the sessions to fit the needs of the individual parent and baby/toddler. For the handout, I broadly listed some topics that were critical to raising an infant/toddler such as: bonding, childhood development and milestones, tantrums, and general parenting support. After discussing potential names for the new program with my supervisor, we settled on Parent and Baby Dyadic Coaching to reflect my level of training as an intern. This was not Parent-Infant Psychotherapy (PIP), which is an evidence-based attachment-focused therapy requiring select training (Barlow et al., 2015). Rather it was an opportunity for parents and infants to receive coaching and individual attention to enhance caregiver-infant attachment, promote infant mental health, and support skill-based learning experientially.

After the handout was approved it was sent to agencies, individuals on the agency list serve, hospitals, and Henry Street Settlement staff. The feedback was positive, and referrals started to come in. I administered intakes for all prospective clients to ensure they were a good fit for the coaching. Given the population that The Parent Center attracted, many parents were working on regaining custody of their children. After checking with my supervisor, and in an effort to meet the needs of the clients, we concluded that while this program was not evidence-based and therefore not court-approved, I could offer clients letters for court rather than a certificate of completion like many of the groups at The Parent Center offer. The letters were brief, and broadly outlined the topics for that week, and positively reflected on the client's commitment and growth throughout the sessions. Three case studies where I engaged in

individual dyadic coaching with three mothers and their infants/toddlers will be used to illustrate the work. All names have been changed to ensure confidentiality.

### **Curriculum Development/ Important Themes**

For some who are living in challenging circumstances, dyadic parent coaching can provide an opportunity to teach skills and techniques to support caregiver-infant attachment. Drawing on resources gathered during my master's program in Child Development, I began to compile information that would guide my curriculum for the coaching sessions such as: prenatal and postnatal brain development; the importance of touch; ways to attune to an infant's cry; potty training; nutrition; Sudden Infant Death Syndrome (SIDS); crib safety; separation anxiety; tantrums; and ways to promote socio-emotional growth.

### **Case Studies**

This section explores three case studies including background information, a description of the sessions, and a discussion section.

#### **Case One- Evette and Hudson**

Evette was an African American single female single parent in her mid-thirties with one child, a son named Hudson who was two-months old at the start of the coaching sessions. She lived in an apartment in NYC and was unemployed. Evette reported that she became pregnant unexpectedly but decided to continue with the pregnancy because she was in her mid-thirties. She reported that she had a normal pregnancy. Evette was referred to The Parent Center after a traumatic birthing experience that resulted in her newborn son being removed from her custody in the hospital. Her son was immediately placed in kinship care with Evette's mother.

Evette shared that her water broke, and she quickly went into active labor. She had planned for her mother to support her through the birthing process, but the fast pace of her birthing

experience prevented her mother from getting there on time and ultimately left her alone during labor and delivery. She reported feeling alone, overwhelmed, and worried about making decisions about vaccinations. Because of this, she requested more time to make these decisions. The hospital reported that Evette refused to sign paperwork allowing her son to get vaccinated and that a case was opened because she became volatile and combative and they worried about her ability to care for her newborn son. She was informed that an ACS case was opened and that her son would not be discharged from the hospital in her care. Evette's mother agreed to have temporary custody of Hudson, but the arrangement left many challenges.

Evette's mother, Anne, had a full-time job and lived comfortably in a one-bedroom apartment. After agreeing to take Hudson she had to take a leave of absence and re-learn how to care for a newborn. Evette was allowed to have supervised visits by her mother with her son at her mother's apartment. Evette wanted to participate in the dyadic coaching program to show the court that she was committed to caring for her son and regaining custody. The coaching sessions took place at The Parent Center. Evette and Hudson engaged in the coaching sessions, but Anne had to be present and stayed in the waiting room. Evette and Hudson participated in six coaching sessions. Selected direct quotes from parts of the one-hour sessions will be included.

Dyadic Coaching Sessions: Evette had many concerns about not being with her son all of the time. She expressed worry that her son would not be comfortable with her and that she would not know what to do with him when she regained custody. She explained that she felt traumatized from the birthing experience and carried a lot of guilt around the separation. After hearing all of this, I understood that she was concerned about forming a secure attachment and caring for Hudson's needs. We agreed to spend the first few sessions focused on building skills

around caring for an infant. We met in the playroom with toys and mats laid out on the floor. We spent the first fifteen minutes of the session sitting on the mats, with Hudson in Evette's arms talking. The casual conversations at the beginning of the sessions helped to build rapport and allowed the mother and baby to get comfortable with me and in the new environment. The conversation then flowed into a discussion around "caring for your infant". An excerpt from our session is provided below for illustration. All dialogue was captured using quick notes during the session and then fully developed through a process recording.

*Eve: "Evette, you mentioned to me that one of your worries is how to know what he needs or wants, is that right?"*

*Evette: "Yeah, sometimes it's like you just don't know what is happening with him or how to fix it".*

*Eve: "So let's spend some time today thinking about what Hudson might need. Let's start with crying... what are some of the reasons Hudson might cry?"*

*Evette: "Umm... he might need a diaper change. I always change his diaper but sometimes it dry"*

*Eve: "Yes, that is a great first thought. So, a good first step would be to feel his diaper and see if it is full or to smell to see if he pooped. But sometimes, we can use clues for example, if you just changed his diaper, it might make sense to try to think about what some of his other needs are before changing the diaper again. It still might be the diaper, but if you just changed it I would try something else first. What are some other reasons Hudson might cry?"*

***Evette:** “He could be hungry. It’s hard because with him not with me, I don’t know you know his schedule and stuff. Like my mom just feeds him when he cries but if he were with me, I would be able to kinda get him on a schedule.”*

***Eve:** “I’m glad you are thinking about a schedule because that is important with infants, but he is still really young and for a lot of caretakers, getting an eight-week-old baby on a schedule is tough. It sounds like it might be hard for you to not know what is happening all day and night with Hudson.”*

***Evette:** “Yeah, it is. It wasn’t supposed to be like this. But I’m glad he’s with my mom. Oh, and sometimes I don’t know if I’m just hearing things but sometimes his cries sound a little different.”*

***Eve:** “Yes, it sounds like this is really hard, and it is okay to be both grateful and still sad about this situation. And you are absolutely correct. I’m really glad you picked up on that, infants do have different cries that mean different things.”*

***Evette:** “Yeah, I be hearing that sometimes, and I’m like what!”*

***Eve:** “Let’s go through some of them. A hungry cry usually is marked by short and low-pitched cries whereas an angry cry might sound more turbulent or exaggerated. If Hudson is in pain or distress his cry might come on suddenly and loudly with a long, high-pitched shriek followed by a long pause and then a flat wail. He may also have a cry for wanting to be left alone, that cry tends to sound similar to the hungry cry”.*

\*Note: after discussing these cries, I pulled up a YouTube video that illustrated with an infant the different kinds of cries.

***Evette:** “Yeah, it’s good to see and hear those cry because sometimes it is so overwhelming to know what he wants”*

*Eve: "I am noticing that we are almost out of time, so I would like you to try and listen during your visits with him this week and see if you can pick up on his different cries.*

*Next week we are going to discuss what else you can do to soothe Hudson after you have tried a diaper change and feeding him."*

*Evette: "Okay, yeah thank you. I will listen for that. Sometimes though he just be crying for so long."*

Evette's mother, Anne, returned downstairs and started to put the infant carrier on.

Evette, who consistently held Hudson the entire session told her mother that she still needed to change him before giving him back. She spent the next fifteen minutes getting him ready to leave before kissing him on his head and handing him to her mother.

During session two, I planned on discussing other ways to attune to Hudson's needs, but in our opening conversation Evette mentioned that Hudson slept in a crib with stuffed animals at her mother's house. After hearing this, I was very concerned because the safest way for an infant to sleep is with nothing else in the crib. I decided in that moment to alter my previously planned curriculum on "activities that help a baby develop" to "crib safety and Sudden Infant Death Syndrome (SIDS)". A central component of this coaching was meeting the parents where they were, so when a discussion around sleeping in a crib with stuffed animals came up and warranted further dialogue, I was able to incorporate new topics into the conversation. This ability to adapt the sessions to meet the needs of the family highlighted the benefits of working in an individual model with a mother and baby.

We discussed SIDS, a term she was unfamiliar with. I paid careful attention to my wording and delivery so that I would not overwhelm her or make her fearful. Instead, my goal was to educate her on SIDS and provide an overview of both facts and ways that caregivers can

help prevent SIDS. We discussed sleep and environmental factors, infant positioning, and crib care. Evette expressed that she understood what I was saying but was worried about telling her mother about removing the stuffed animals from the crib. After a bit of discussion, she told me that she feared her mother would say, “I always had stuffed animals in your crib, and you were fine.” This highlighted the challenge of working with a family system across different generations, and the beliefs that caregivers hold around the “right” way to care for an infant. We discussed this issue, and problem solved together. We agreed to send Evette and Anne home with a handout on SIDS (found on the internet) that highlighted some of the concerns we discussed. This handout would serve as a tool to help Evette talk about this issue with Anne.

The rest of the session was spent demonstrating and practicing the “swaddling” technique. Laying Hudson down on the mat, I showed Evette how to swaddle Hudson and then had her demonstrate as well to ensure that she understood. In addition to the traditional swaddling that constricts movement of an infant’s arms, I showed her how to swaddle Hudson with his hands out and explained that he might want his hands free as he got older. We discussed the purpose of swaddling, and how in some ways it mimicked the security Hudson felt in her womb.

During session four we continued the discussion from previous weeks by talking about Hudson’s different cries. Evette shared that sometimes she picked up on what the cry meant, but other times she could not. I reassured her, normalizing the experience, and explained that motherhood is all about learning, adapting, and growing and that it could take time. We continued the conversation about caring for the needs of an infant. However, unlike session one, we discussed ways to attune to his needs after Evette tried feeding and changing his diaper. I explained that a good general rule to follow is that infants need one additional layer of clothing than adults. I instructed her in some cases, Hudson may be too hot or too cold and to check the

tip of his nose as a guide. If it felt cold, she could add another layer and if he felt warm, he might want one less layer. Additional conversations from session two will be provided below to illustrate the need to connect caring for an infant with promoting healthy attachment between mother and baby.

*Evette: "Sometimes I try all those things, but he still cries."*

*Eve: "What are some other reasons he might be crying?"*

*Evette: "He might not feel good or something".*

*Eve : "Yes, that is a good thought. He might not be feeling well and sometimes that has to do with being burped or if his stomach is hurting there is a technique that I am going to show you to help him relieve gas. May I hold him for a minute to show you?"*

*Evette: "Yeah, sure."*

(Evette handed Hudson to me and I placed him on his back on a mat. I proceed to show her how to lay him down on a flat surface, and with bent knees, bring his knees to his chest and gently apply pressure by pressing and then straitening the legs out and repeating. I demonstrated the motion several times, and then asked Evette to take over and show me how to do this technique.)

*Evette: "Wow, yeah I am going to try this because he gets really gassy and then he fusses like a lot. Sometimes I just want to leave him there crying because I don't know what do to."*

*Eve: "Sometimes it can be very overwhelming. But why do you think it is so important to respond to him when he cries?"*

*Evette: "Umm... maybe so I can fix it for him?"*

***Eve:** “Sometimes you will be able to fix the situation but other times you may not be able to right away, but by responding to his needs, you are demonstrating to him that you care for him and can attune to him. During infancy, it is very important for Hudson to have caregivers that respond to his needs so that he can develop a secure attachment. A secure attachment with caregivers will create a secure base to explore the world and create other relationships.*

***Evette:** Asked tearfully, “Since he has two caregivers right now, will he still know that I am his mom?”*

When Evette asked this question, my immediate response was to feel sad. This question highlighted the pain and worry for a mother who was separated from her infant around the maternal bond and the impact that separation can have on attachment.

***Eve:** “One of the strongest senses for an infant is smell, Hudson is able to tell the difference between your smell and someone else’s. Right now he has two caregivers, you and your mother and there is nothing wrong with that. I can imagine that it must be hard for you to not be his primary caregiver at the moment, but by continuing to show up for him and care for him during visits, you are demonstrating to him that you are an attentive and attuned caregiver. You are laying the foundation for future positive interactions.*

***Evette:** “It wasn’t supposed to be like this and I don’t know how much longer it will take to get him back”.*

***Eve:** “As hard as it may be, I want you to try and look at what you ARE doing well as a mother. This situation has certainly challenged new motherhood, and may not be what you thought it would, but I want us to identify some of your strengths.”*

*Evette: "I mean I guess I go to see him every day. I buy him stuff that he needs."*

*Eve: "Yes, those are both important. Even though it takes you an hour to get to him, every day you go to see him and spend time caring for him. You are also taking financial responsibility for him. I want to add another strength that I see if it's okay with you?"*

*Evette: "Yeah, that's fine"*

*Eve: "You are actively engaging in strengthening your parenting and putting in the work and the steps to get him back home with you. You have channeled your anger and frustration about the situation into using this time to learn techniques and skills to help you attune to him. To me, I see that as a huge strength."*

I engaged in dialogue using a strengths-based perspective. According to Swenson, a strengths-based perspective helps to empower and empathize with clients as opposed to "...pathologize, emphasize deficits, and blame the victim" (1998, p 532). Using this model with Evette allowed us to shift the conversation away from some of the challenging dynamics that she was stuck on, to discuss and highlight what she was doing well.

In addition to talking about strengths, organic situations during the sessions provided learning opportunities and room for growth. For session five, I planned to discuss the importance of communication with an infant. After spending some time talking, I realized that I left my notebook at my desk in the other room. Leaving the door open, I explained that I would be right back. At this point, Hudson was on the mat laying on his back with a blanket covering the lower half of his body. I watched as Evette stood up, leaving Hudson on the mat unattended and went to grab something from her backpack. When I returned, the blanket was covering Hudson's face. I was there to pull the blanket down, but this situation provided an important learning

opportunity. Evette returned less than a minute later but we spent the session talking about the potential risks and what could have happened if Hudson struggled to breathe under the blanket. This led us to discuss how caring for an infant changes as they get more mobile. We discussed how to safely leave an infant unattended, by placing them in a strapped seat, because it is unrealistic to hold an infant or watch them at all times. We talked about water safety and concluded the session by discussing that the coaching was coming to a close. Together we agreed to spend the final session on communication between caregiver and infant.

Session six started as all of the other sessions did with discussion. Evette happily shared with me that Hudson had started smiling. She then expressed concern because Hudson developed a diaper rash. We spent the first part of the session talking about potential causes of a diaper rash, such as leaving a wet or stool filled diaper on for too long. I gave her some diaper rash cream that was donated to The Parent Center and I advised her to consult his pediatrician if it continued for a long period of time or if it worsened. After attending to the immediate needs of Hudson, we shifted the conversation towards communication between a caregiver and infant. I asked Evette to lay Hudson down on the mat. Together we observed his movements and sounds. Below is a conversation that took place in our final session around communication.

***Evette:** “He can’t even talk yet so what do you mean by communicating?”*

***Eve:** “That is a good question. I want to answer that question by showing you something. Sit right here (I directed her to sit below his feet with him looking up at her). What is he doing right now?”*

***Evette:** “Um, I guess he is moving his legs and arms and making sounds.”*

*Eve: "Yes, he is communicating to you that he is content and happy. But infants don't just communicate when they are happy. What are some other ways he communicates with you?"*

*Evette: "By crying or fussing."*

*Eve: "Yes, exactly. In some cases, Hudson drive the communication, by crying or fussing. He is trying to communicate to you that he needs or wants somethings. Other times he might drive the communication by smiling at you and you may respond by smiling back. In other situations, you may lead the conversation, by smiling at him and he smiles back."*

*Evette: "You know what's funny?"*

*Eve: "What?"*

*Evette: "I used to see parents talking all silly to their children and thinking they were nuts, but I guess that is what we should be doing!"*

*Eve: "That is a good observation. Sometimes during parenthood, we might do things that other people think are silly. Yes, talking to a child who cannot use words to communicate back may look silly, but it serves an important function in development. By talking to Hudson, you are showing him that you are engaged and that helps him to feel loved and secure. It also helps him to learn about how to take turns, because he speaks, then you speak or vice versa. There are so many benefits of talking to your infant like helping him to learn that sounds have meaning. Talking to him will also help him to learn words not*

*for a while but eventually. You will find that even before he can speak, he will be able to understand words and simple directions that you give him.*

***Evette:*** *“Wow, I didn’t really know any of that. I guess I will just start talking to him about random stuff.”*

This conversation emphasized the importance of early intervention work and the impact on later development. Helping Evette to understand the importance of communicating with Hudson, allowed her to see how it could impact later development of language. We concluded the sessions by talking about her strengths as a mother and resources she could draw on later on if she wanted, such as free parenting classes, toddler groups, and other Parent Center offerings. We discussed her progress, and her evolution from a new mother who was scared and worried about the separation to a mother who felt confident that she was spending her visits promoting healthy attachment and continuing to be a strong support in his life.

#### Case Two- Robin and Mia

Robin was an African American female single parent in her mid-twenties with three children. Two of her children had been adopted to other families, and she was working to regain custody of one of her children, a daughter named Mia who was 18 months old at the start of the coaching sessions. Mia lived with Robin’s mother after ACS removed Mia from the home, but Robin was allowed to have unsupervised visits with Mia and take her outside of her home. Robin, who was diagnosed with depression, was unemployed, resulting in low socio-economic status. Robin and Mia were referred for dyadic coaching from their caseworker who thought they could benefit from additional support. Robin was able to pick Mia up at her grandmothers and bring her to The Parent Center for the sessions. Mia had been with her grandmother since she

was five-months old after the pediatrician made a report that Mia was undernourished. Robin reported that her relationship with her mother was, “okay” sharing, “I mean I guess it’s fine. She took Mia which you know was good, but I want her back now and I feel like my mom is not helping me to get her back.”

**Dyadic Coaching Sessions:** The coaching sessions with the toddlers differed from those with infants, because a lot of time was centered around making the toddler feel comfortable without being held by their caregiver. The new environment of the playroom offered new toys for Mia to play with, but it was overwhelming at first. During the first session, I planned an art activity to engage Mia. Prior to the start of the session, I laid out paper and dot pens (thick pigmented markers with a round dot at the bottom used for stamping). Robin and Mia arrived twenty-minutes late leaving only forty-minutes for the meeting. When Robin and Mia arrived, I introduced myself and then asked Robin to take Mia out of the stroller and direct her towards the back room. Below is part of the initial discussion that took place when they arrived.

**Eve:** *“I set out some art supplies. I wonder if Mia likes to color?”*

**Robin:** *“Mia look at that... yes, you like to color.”*

**Eve:** *“I like that you just directed her attention to the coloring. Maybe if she sees you engaging in it, she will want to do it too.”*

**Robin:** *“Okay. I’m going to color now!”*. (Robin sat at the table and began to use the stamper. I watched as Mia glanced back and forth at me and her mother who was coloring. After less than a minute, Mia walked to see what her mother was doing. Within two minutes, she was engaging in the art activity).

**Eve:** *“Wow... Mia, look at that art you are doing. I see you stamping”* (Mia held her picture up to show me).

**Robin:** *“Wow, I have never seen her get comfortable so fast. She must really like you!”*

**Eve:** *“She is showing us that she feels comfortable in this situation and likes the activity. You also helped her to feel comfortable in this new situation by taking the lead and stamping first”.*

While Mia continued her art activity, we used the time to discuss family dynamics, financial stress, and what Robin was wanting to focus on during our sessions. Robin explained that she was hoping to regain custody of Mia soon, and that she would need to put her in daycare. The daycare that she planned to send Mia to required that the toddlers be potty-trained. Robin expressed that she had no idea how to even start with potty training. We agreed to spend some time focused on getting Mia ready for potty-training. After some discussion, we directed our attention to Mia. I guided them to the playroom where we spent the rest of the session. Robin and I continued talking while also playing and interacting with Mia to help her get comfortable with the new surroundings. At the end of each session, Mia got to pick a book from our donation section to bring home. Incorporating this small reward into the end of our sessions acted as a signal to Mia that the meeting was coming to a close, supported activities that promoted cognitive and language development, and strengthened caregiver-toddler attachment.

Session two and three were centered around potty-training, however each session opened up with a toddler-centered art activity. I printed coloring pages and provided crayons and markers for Mia to use. The art activities were age appropriate and required only a few materials. This was intentionally done to show Robin that she could do these activities too. I asked Robin what material she had at home. It was important to facilitate projects that incorporated materials that she had easy access to because often art materials are expensive. If I spent part of the session talking about materials that were inaccessible to her and cost prohibitive, she may have tuned out

what I was saying or worse, found me to be insensitive to her current financial situation. Instead, the conversation allowed us to talk about introducing Mia to some coloring, painting, or stamping projects both at Robin's mother's house and eventually when Mia returned home. The art activity allowed me to introduce the topic of potty-training to Robin. An excerpt of the dialogue is below.

**Eve:** *“Potty-training is a huge developmental milestone. There is a lot to think about before beginning to potty-train Mia.”*

**Robin:** *“Yeah, that's true. And like since she is at my mom's house, it is really hard because I am not there all the time. But soon she will be able to come to my place during the day sometimes, so I can start to get her ready.”*

**Eve:** *“That is a very good point, since she may be going between two homes, we have to think about the impact that changing environments has on her. Consistency is a big part of potty-training. Before we get into how to potty-train Mia, lets discuss if she is ready to be potty-trained. Typically, toddlers show that they are ready to be potty-trained between 18-24 months of age, however others may not be ready until later. There are physical, behavioral, and cognitive signs. Some physical ways that she might show you that she is ready for potty-training is by being able to walk and run steadily.”*

**Robin:** *“Yeah, she can do that!”*

**Eve:** *“Great. Another sign is being able to urinate a fair amount at once and having regular bowel movements at around the same time.”*

**Robin:** *“Um I mean it's hard for me to know because I am not always with her, but I think she does. This is why I want to bring her home, so that I can start to really see what is going on.”*

Kinship care provided many challenges for both Robin and Mia and the example of potty-training illustrated some of the pressures that mothers like her face while wanting to help her daughter developmentally progress. In addition to discussing the physical signs that signal a toddler is ready for potty-training, we discussed the behavioral and cognitive signs such as expressing words for urine and stool, following simple directions, discomfort with a wet diaper, budding independence, and an ability to pull her pants up on her own. We concluded both sessions by engaging in child-centered play. Through play, I was able to model ways for Robin to engage Mia and promote development through creativity.

During session four, Robin came thirty-minutes late and appeared upset. After setting Mia up with a watercolor activity, I learned that Robin found out that she was four months pregnant. She shared with me that she was feeling very overwhelmed and had lots of worries about caring for an infant, financially supporting an infant, and having enough space in her apartment for the new baby and Mia (once she gained custody of Mia). She told me that she was feeling depressed during the past week and had skipped some visits with Mia. After listening to some of her worries, I followed up about the potty-training and Robin shared that she was too overwhelmed to focus on potty-training right now. I assured her that when Mia was ready, Robin could attend a workshop on potty-training that The Parent Center offers.

This example illustrated what could happen when working individuals with many significant stressors. Robin had concerns about stability, shelter, and mental health and all of these compounding stressors pushed her to be too overwhelmed to be dealing with potty-training. We spent two sessions on potty-training readiness only for Robin to express that she could not handle another change at that time. While we could have used those two sessions to focus on attachment-related concerns, those discussions were not a complete loss. It laid the groundwork

for future readiness for Robin and Mia. Towards the end of the session, Robin asked if we could talk about temper-tantrums because she reported that Mia was having a lot of temper tantrums when she was not getting what she wanted. By this point in our sessions, Mia was sad when the meetings came to an end and sometimes cried as she left.

The following week, Robin called me to say that she could not attend the fifth session because she had court. We agreed to skip a week and pick up with session five the following week. I began session five by following up with Robin about her depression and how she felt during the past week. Robin and Mia arrived only ten-minutes late. Robin told me that was feeling “okay”, and I pointed out that it was a strength to be able to get out of bed, pick up Mia from her mother’s house, and arrive for an appointment. Using this strengths-based model reinforced what she was doing to not only care for herself, but for Mia rather than focusing on her lateness. While Mia was coloring a paper plate that was cut out into a butterfly, I used that time to discuss self-care with Robin. Part of the conversation is below.

***Eve:** “Robin, have you ever heard of the term self-care?”*

***Robin:** “No, I haven’t.”*

***Eve:** “Self-care is about caring for yourself physically, emotionally, and mentally. The idea is that we need to care for ourselves so that we can care for others like children.*

*How do you think self-care impacts parenting?”*

***Robin:** “Um maybe like if I don’t work on my depression, and like stay in bed all day then I miss a visit with Mia or I show up late sometimes.”*

***Eve:** “That is a good example. Sometimes we need to prioritize our mental health because depression can definitely take a toll on how much energy you have do things. Have you thought about seeing a therapist, psychiatrist, or your doctor?”*

**Robin:** *“Yeah, I have to go back. I kinda stopped going but yeah it’s coming back so I should go back. My doctor used to give me meds and I was in therapy too, but I stopped.”*

**Eve:** *“What is coming back?”*

**Robin:** *“My depression, I stopped going and stuff because I felt fine. I didn’t really need it anymore.”*

**Eve:** *“Another way to think about mental-health services like therapy is that even during times where you do feel good, it can be a good check-in. Therapy does not just have to be for when you are struggling. Therapy is an example of self-care.”*

**Robin:** *“Yeah, I’m going to call. I want to feel better for Mia, you know?”*

**Eve:** *“Yes, I know that she is very important to you so it sounds like you want to get to a place where you feel better so that you can be there for Mia.”*

**Robin:** *“Yeah, I do.”*

When working in a dyad with a mother and toddler, you have to attune to the needs of mother and child. Mental health, and specifically depression, can impact the caregiver’s ability to meet the needs of the child. It felt important to discuss caring for Robin, and to bring up therapy because in order to care for Mia, Robin first needed to care for herself. During the end of the conversation, Mia went over to her stroller and picked up her mother’s phone. Robin took it away from her and Mia threw herself on the ground. I observed for a few minutes, watching as Robin told Mia to stand up. Robin remained seated in her chair, removed from Mia, as she continued sprawled out on the floor. After a few minutes, I intervened. I bent down to the same level as Mia and asked Robin to watch the interaction. I proceeded by attuning to her feelings and then attempted to redirect her. I picked her up and brought her to the window. I discussed

with Robin the importance of getting on her eye level and acknowledged her feelings of being upset. Then I encouraged Robin to redirect Mia, explaining that toddlers can easily be redirected.

I also talked with Robin about reasons why Mia may be tantrumming such as during transitions, when she is very hungry, or when she is over tired. We talked about where Mia was developmentally, and how in this phase she was working on building independence. We ended the session by discussing how we wanted to conclude the coaching. We decided we would talk about developmental milestones and ways to promote development.

Before our final session, COVID-19 hit New York City and all interns were pulled from their placements. As a result, I was not able to have the final coaching session or properly terminate. I called Robin to inform her that unfortunately, I would not be returning in person to The Parent Center. I encouraged her to use The Parent Center as a resource.

#### Case Three- Grace and April

Grace was a single Caucasian female in her early sixties with one child, April who was twenty-two months at the start of the coaching sessions. Grace found out about The Parent Center through a friend and called about different services. After talking to her on the phone, she seemed like a good candidate for the coaching and agreed to coming to The Parent Center with April once a week for six weeks.

Despite her age, Grace had a natural delivery and gave birth to a healthy baby. Grace reported that she had no family support and little friend support, because many of her friends were already grandparents. Grace shared that she had a history of Alcoholism but had been sober for over thirty-years. Grace appeared very high functioning and received a higher education graduate degree. She shared that she was struggling a lot financially and was on social security. She had no ACS involvement, and was just looking for parenting support.

Dyadic Coaching Sessions: Unlike many of the other sessions, Grace guided our initial conversation in the first session. She shared in great detail about April, her likes and dislikes, her strengths and developmental areas that she was worried about with April. She expressed worry about not knowing what she was doing, and about creating the best environment for April to grow even though they were under extreme financial stress. April walked right in, and immediately gravitated towards the easel with markers. Within seconds, she was scribbling on the easel and handed her mother and me markers to help her take the cap off. These observations lead to our next conversation which is provided below.

*Eve: "April seemed to get comfortable quite quickly."*

*Grace: "Yes, she has a very strong personality. I often struggle because of course I want to promote her strengths and gusto for life, but sometimes her strong personality can be overpowering. I can also tell she really likes you; she does not usually get this conformable with people so quickly."*

*Eve: "It is interesting that you brought up promoting her strengths, which is certainly important, but we can also spend some reflecting on temperament and how that impacts your parenting and different parenting styles."*

*In a loud voice, Grace starts saying, "Oh April, that is wonderful artwork. Oh April, that is just so beautiful. Wow, April!" I was surprised by the level of enthusiasm that Grace was displaying and decided to inquire about it.*

*Eve: "Grace, do you and April do a lot of art projects at home?"*

*Grace: "No, in fact, this is really showing me she is ready for these kinds of projects. I will need to purchase some art supplies because she just loves this. Oh, she is going to be*

*excited to come every week. Art supplies are so expensive these days and she is in a destructive phase so I worry.. but yes I am going to get some maybe.”*

***Eve:** “Yes, art supplies can be very expensive. One suggestion would be to buy some supplies at a dollar store. That way, if April destroys it, only a few dollars are lost.”*

***Grace:** “Yes, that is a great idea. She must be getting so much developmentally from this experience!”*

***Eve:** “Yes, she is developing fine and gross motor skills as well as fostering creativity. Self-expression at her age is important.”*

This conversation illustrated that cost can be prohibitive, even for parents who understand and value promoting development through art and other activities. The coaching sessions targeted the attachment relationship, but also sought to promote developmental skills. It was clear that both Grace and April had vibrant personalities. The session came to a close in the same way it did for Mia and Robin. April got to pick a book off of the shelf and both April and Grace were happy to be going home with something new to read.

I planned for session two and three to be spent focusing on potty-training. Grace and April came whirling in. Grace immediately began talking about how many times they read the book I gave them, and April went running to the stamping art project that was set up. The art allowed April to be engaged in a project, creating space for Grace and me to discuss potty-training. Some of the dialogue is captured below.

***Eve:** “We are going to spend some time understanding if April is ready to be potty-trained because it is a huge developmental milestone, and we want to make sure she is*

*ready. If you start too early, the process takes longer and is difficult on both you and April.”*

**Grace:** *“I am so glad I can consult you on this, there are so many things to think about and you know, I haven’t done this before so it’s all new, but I love all of it you. I am so happy to have this little one (pointing to April who is happily stamping with different colors on paper).”*

**Eve:** *“I can tell that you are really basking in new motherhood, but even so there are many aspects of parenting that present challenges. So let’s discuss if she is ready to be potty-trained. Typically, toddlers show that they are ready to be potty-trained between 18-24 months of age, however others may not be ready until later. There are physical, behavioral, and cognitive signs. Some physical ways that she might show you that she is ready for potty-training is by being able to walk and run steadily.”*

**Grace:** *“As you see, she can definitely do that. She is so coordinated and often climbing on things in the apartment! I am not a young mother, so she gives me a run for my money... sometimes I think about that a lot. April is my only, and given my age, she will be an only child. I worry that she will grow up very lonely.. I’m rambling... I don’t know if I am making sense?”*

**Eve:** *“You are making sense. It can be hard to think about, but one thing to think about is that you are providing such a loving foundation for her. She will learn to build a community that supports her.”*

**Grace:** *“Yes, that is very true! That is a good way to think about it. Sorry, let’s get back to potty-training.”*

*Eve: “Another sign is being able to urinate a fair amount at once and having regular bowel movements at around the same time. Do you notice that she has a schedule to her pooping?”*

*Grace: “Yes, she is fairly regular with her poops, and they are healthy poops! Sorry if that is too much detail.”*

*Eve: “As someone who loves children, I have no issue with discussing poop and pee!”*

Grace was highly motivated and attentive to April’s daily routines, but being a single older parent presented challenges. Grace expressed concern about April being an only child, and worried about April growing up with no siblings. It was important to acknowledge Grace’s concern but also provide an alternative way of looking at the situation. I observed that sometimes client’s express concerns or worries embedded in other conversations, for example potty-training. For some, it may be more manageable to introduce a topic and then be able to discuss something else. We went back to talking about potty-training. I encouraged Grace, if she was comfortable, to have April watch as Grace used the bathroom, flush, and even wash her hands. After that, I instructed Grace to have April sit on the potty to get accustomed to it. By the third session, Grace reported that April was able to sit on the toilet for a few minutes. We discussed using positive reinforcements even for sitting on the toilet.

In session four, Grace came to the meeting very upset. She explained that she brought April to her gym where childcare was provided but that April had a “complete meltdown”. Grace was very upset because April had not spent a lot of time with others and blamed herself for not helping her to socialize sooner. She feared that April wasn’t developing independence. Grace was crying and shared that she had “failed as a mother”. I engaged April in an art activity and began discussing separation anxiety with Grace. A section of the dialogue is below.

**Eve:** “Grace, I can see that you were really worried by the interaction that happened at your gym, it must have been hard to watch April melt-down”.

**Grace:** “Yes, it was the first time I tried to leave her for any period of time. I mean... I can't always be with her. I want her to be comfortable with other people.”

**Eve:** “We are going to spend some time talking about separation anxiety, but first I want you to think about why it might've been so hard for April to separate from you?”

**Grace:** “I guess because she feels safe with me.”

**Eve:** “Yes, exactly. She has a strong, secure, and trusting relationship with you, which is a very positive thing. Her secure relationship with you will actually help her to be more independent later on in life. However, now I have a few tips that may help with separation. It is important for April to feel safe with the person that she is going to be left with. That's not going to happen right away, so I would encourage you next time to spend some time with April and the new caregiver to build a relationship before leaving her with that person. Plan to get to the gym 10 or 15 minutes before you actually want to start working out so that you can spend time helping April to acclimate to the new environment and person. When you do leave her, is important to have some kind of routine such as giving her a kiss or leaving her with something that brings her comfort, like a blanket or stuffed animal. Some people refer to this as a transitional object which you may have heard before. This familiar object can bring them comfort in your absence. When it is time to leave, I would encourage you to verbalize that you're leaving instead of just sneaking out. Communicating with her that you're going to leave and then showing her that you'll return is important for her development and building a trusting and secure relationship. When you do leave, do not drag it out. It's often more painful for

*the parent and the toddler when parents keep coming back to give more kisses or more hugs (I watch as Grace takes out her notebook and begins taking notes).*

**Grace:** *“These are really good tips...I am going to try them this week and let you know how it goes. It is hard to watch her when she is so upset, but I need this time for myself and to show her that she will be okay.”*

Watching how April and Grace interact with each other allowed me to coach Grace in a way that aligned with her parenting style. While parent coaching can be helpful, being able to see the communication style and interactions between April and Grace, and work with both parent and child was beneficial. Like previous sessions, this meeting ended in the “playroom” engaging in play with April. I noticed that Grace was constantly speaking to April and was guiding the play. Grace seemed to offer many answers, without giving April a change to express anything. I made a note to discuss child directed play the following week.

Grace and April came in for week five of the coaching sessions. Grace happily shared that she was able to drop April off for child-care at the gym three times during the week. She shared that the first time was difficult, but that she referenced her notes from our session. While April was coloring a butterfly cut-out, began a discussion with Grace about play. I directed April and Grace to the playroom where I spend a few minutes observing, as I did in previous weeks. I watched as Grace came up with a scenario, handed toys to April, and led the play. Below is part of our session.

**Eve:** *“Would it be okay if I point out a few things that I am noticing?”*

**Grace:** *“Yes, please do!”*

**Eve:** *“I notice that you are on the same level as April, which is really great, but it seems like you are the one who is driving the play. April looks like a follower in this play*

*situation rather than the initiator. I'd like to see what happens if you take a step back from being the leader and have April direct the play.*

**Grace:** *"Yes, yes.. okay!" Grace put the play forks and spoons down on the floor and watched as April took charge. April went over to the pretend oven and put a pan on the stove. She shook it around and poured the pretend contents of the pan onto the plate. She walked over to Grace and handed it to her. Grace said, "thank you April, yummy!". Instead of talking more, Grace stopped, and April said, "More?". The play continued like this for fifteen minutes as April "prepared" food and gave it to Grace.*

**Eve:** *"How was that for you?"*

**Grace:** *"I did not know she could communicate all of that to me. I guess I tend to direct things.. even the play it seems. She usually just follows along but I know see that maybe that was because I was not giving her a chance to direct the play."*

**Eve:** *"It's not always a bad thing, sometimes you can take charge with the play but it is also important that April has a sense of agency over the play too. You want to stimulate her creativity."*

This interaction demonstrated the importance of observing parent-toddler interactions and then offering guidance and suggestions to enhance the caregiver relationship. While Grace was not doing anything wrong, I was able to address observations with curiosity rather than judgement. I intentionally started the conversation by stating something that Grace did well and then proposed a new way of interacting. We concluded the session by talking about toddler socialization. Grace had no friends with children April's age, so April was not around many other toddlers. Grace expressed feeling isolated. I suggested that Grace and April join the toddler group offered at The Parent Center.

Similar to Mia and Robin, COVID-19 prevented Grace, April, and me from having the sixth and final session. I called Grace when I found out that I would not be returning in person for internship. Grace was very upset that April would not be able to properly say goodbye to me, as she shared that I was one of few people in April's life. We discussed together that this was not a proper termination, but it was the best we could do given the current situation. Grace shared with me that she was very concerned about COVID-19 and its impact on New York City. Unlike many clinician and client interactions, we shared a common feeling of worry about COVID-19 and all of the unknowns. Grace shared that she felt like she gained a lot from the coaching. I encouraged her to use The Parent Center as a resource to her going forward.

### **Reflections and Observations from the Sessions**

In order to work effectively with each dyad, I needed to meet each family where they were. The coaching sessions operated as an open system, as noted in social work macro practice, "as open systems, clients both give to and draw from elements external to themselves" (Netting, 2012, p 173). Beyond just what is occurring within their bodies, their environment plays a large part in how they feel, react, and understand the world (McQuaide & Ehrenreich, 1997). Some environmental factors impacted the coaching sessions. In some cases that meant altering the curriculum to discuss an unexpected complication or stressor. In those situations, I had spent time researching and planning a curriculum, only to forgo it for something else. I had to be very adaptable. For those sessions, I did not have time to search the internet or consult a textbook. I had to rely on the skills and knowledge within myself. For this reason, as well as others, the coaching sessions were both exciting and intimidating. I pushed myself clinically, outside of my comfort zone and learned to trust myself more.

The toddler dyadic sessions with Mia and April differed from the infant dyadic sessions with Hudson. For the toddler sessions, the activities were centered around the toddlers, and the coaching was done through the work with the toddlers. The toddler activities guided the instruction, giving them more of an active role in the coaching. In both the infant and toddler coaching sessions, my role was to provide support to the caregiver as they enhanced their attunement and strengthened their attachment with their child. During some of the sessions, I had wished that the clients were also engaged in group work to strengthen their sense of community and provide the children socialization with other kids their age.

Working with non-mandated clients meant that I was engaging with parents who actively wanted to enhance their attachment relationship with their child. They had an openness and ability to receive feedback that was sometimes hindered with mandated clients. Engaging with parents who were committed and voluntarily participated may have resulted in more positive facilitator-client interactions.

I actively worked to ensure that each curriculum aligned well with the values and principles as stated in The Code of Ethics. The Code of Ethics emphasizes the value in human relationships “Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families...” (2017). Some of my curriculum was created prior to working with an individual family, and even though I created the curriculum to apply to a diverse population, I felt it was necessary to tailor it to best fit the needs of the individual families. This allowed me to be sensitive to client’s environmental, cultural, and developmental needs.

COVID-19 directly impacted my coaching work with two of the families. For Mia, Ruth, Grace, and April our sessions were cut short and I was unable to properly terminate. I was

processing all of the new changes at the same time as the clients. I had hoped to be able to discuss their progress and to hear feedback about the sessions. The sessions came to a harsh close and it felt unfinished.

## CONCLUSION

I previously held beliefs, rooted in my cultural bias that in order to be a “good” parent you need to provide your child with lots of opportunities and be both emotionally and physically available for your child at all times. This bias stemmed from my upper middle-class upbringing with two happily married and involved parents. I will reluctantly admit that I used to think that parents who struggled with substance abuse, abused their own children, or struggled with severe mental illness were unfit to parent.

Working with clients at The Parent Center gave me a sharp window into the different methods of parenting and helped me to realize there are many different ways in which you can be a “good” parent without possessing all of the qualities I previously deemed as necessary. I saw the systemic and economic barriers that plagued my clients and their desperate desire to be reunited with their children. Many of the caregivers struggled with mental health, poverty, past trauma, or other significant stressors but they were for caregivers who have struggles of their own, but they were committed to learning how to better attach to their baby, nurture them and build a secure attachment. While many of the parents I worked with could not buy their children everything they needed or rid themselves of stressors, they showed up for their baby and sometimes that is enough.

Ultimately, babies come already “designed”, or some might say “programmed”, to be deeply interested in the people and world in which they find themselves (Stern, 1985). Although an infant’s language lacks words, it is rich with facial expressions, crying, cooing, and gurgling. Early intervention helps in promoting emotional well-being in young children and their families (Zeanah et al, 2000). Caregiver-infant attachment can be strengthened by early intervention models in individual or group settings. Each model offers benefits as well as drawbacks. Perhaps

a combination of both group and individual sessions could provide the opportunity for community as well as a chance to discuss the individual needs of the family. By promoting infant mental health, we are laying the groundwork for a healthy foundation (Barlow, 2009). While it is true that infants have needs, the way in which those needs can be satisfied is broad. We need to look at the needs of the parent and their limitations in order to better serve them and their infants during a developmentally critical time.

## References

- Ainsworth, M. (1964). Patterns of attachment behavior shown by the infant in interaction with his mother. *Merrill-Palmer Quarterly of Behavior and Development*, *10*(1), 51-58.
- Ainsworth, M. D., & Bell, S. M. (1970). Attachment, Exploration, and Separation: Illustrated by the Behavior of One-Year-Olds in a Strange Situation. *Child Development*, *41*(1), 49.
- Altman, N., Briggs, R., Frankel, J., Gensler, D., & Pantone, P. (2010). *Relational child psychotherapy*. New York: Other Press. (Chapters 6 and 7).
- Barlow, J., & Svanberg, P. O. (2009). *Keeping the baby in mind: Infant mental health in practice*. London: Routledge.
- Barlow, J., Bennett, C., Midgley, N., Larkin, S. K., & Wei, Y. (2015). Parent-infant psychotherapy for improving parental and infant mental health. *The Cochrane database of systematic reviews*, *1*, CD010534. <https://doi.org/10.1002/14651858.CD010534.pub>
- Bowlby, J. (1979). Chap. 7: The making and breaking of affectional bonds. In: *The Making and Breaking of Affectional Bonds*. NY: Basic Books.
- Brazelton, T.B., & Cramer, B.G. (1990). *The earliest relationship: Parents, infants, and the drama of early attachment*. Reading, MA: Addison-Wesley Publishing Company. (Preface and Parts One, Four, and Five)
- Brown, P. (2008). *Perspectives in medical sociology*. Long Grove, IL: Waveland Press.
- Cassidy, J., Jones, J. D., & Shaver, P. R. (2013). Contributions of attachment theory and research: a framework for future research, translation, and policy. *Development and psychopathology*, *25*(4 Pt 2), 1415–1434. <https://doi.org/10.1017/S0954579413000692>

DeKlyen, M., & Greenberg, M. T. (2008). Attachment and psychopathology in childhood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 637–665). New York: The Guilford Press.

Dolman, A., Schwartz-Bechet, B., & Davis, D. J. (2018). *Motherhood in precarious times*. Bradford, ON: Demeter Press.

Edwards et al. (2005). <https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1009&context=famconfacpub>.

Finger et al. (2017). Parenting contributors to early emerging problem behaviour in children of mothers in methadone maintenance treatment. *Infant and child development*. doi:10.1002/icd.2042.

Fonagy, P. (2003). The Development Of Psychopathology From Infancy To Adulthood: The Mysterious Unfolding Of Disturbance In Time. *Infant Mental Health Journal*, 24(3), 212-239.

Fraiberg, S., Adelson, E., & Shapiro, V. (1975). Ghosts in the Nursery. *Journal of the American Academy of Child Psychiatry*, 14(3), 387-421. doi:10.1016/s0002-7138(09)61442-4

Gil, E. (2017). *Posttraumatic play in children: What clinicians need to know*. New York: The Guilford Press.

Greenspan, S. I., & Wieder, S. (2006). *Infant and early childhood mental health: A comprehensive, developmental approach to assessment and intervention*. Washington, DC: American Psychiatric Pub.

- Guo, G., & Harris, K. M. (2000). The mechanisms mediating the effects of poverty on children's intellectual development. *Demography*, 37, 431-447.
- Harkness, S., & Super, C. M. (1996). *Parents' cultural belief systems: Their origins, expressions, and consequences*. New York: Guilford
- Henry Street, (2019). Parent Center. Retrieved from <https://www.henrystreet.org/programs/primary-behaviorial-health/parent-center/>
- Holland, S. (2008). *Infant Mental Health Journal*, 29(6). doi:10.1002/imhj.v29:6
- Lieberman, A. F. (1993). *The emotional life of the toddler*. New York: The Free Press.
- Luby, J. L. (2017). *Handbook of preschool mental health, second edition - development, disorder*. Guilford Publications.
- Martha E. Edwards, PhD. (2014, May 24). Retrieved December 17, 2014, from <http://www.ackerman.org/martha-edwards-phd/>
- McQuaide, S., & Ehrenreich, J. (1997). Assessing client strengths. *Families in Society*, 78, 201-212. doi:10.1606/1044-3894.759
- Mori, H., & Kuniyoshi, Y. (2010). A human fetus development simulation: Self-organization of behaviors through tactile sensation. *2010 IEEE 9th International Conference on Development and Learning*. doi:10.1109/devlrm.2010.5578860
- Murphy, A., Steele, H., Bate, J., Nikitiades. (2015). Group Attachment-Based Intervention. *Family & Community Health*, 38(3), 268-279.
- National Association of Social Workers. (2017). *Code of ethics*. Washington, D.C.: Author. Retrieved from <https://www.socialworkers.org/About/Ethics/Code-of->

Ethics/Code-of-Ethics-English.

Netting, F.E., Kettner, P.M., McMurtry, S.L., & Thomas, M.L. (2012). *Social work macro practice* (5th ed.). New York, NY: Pearson. Chapters 7-9

N. (1994). Early Head Start. *Zero to Three- Advisory Committee*.

Salomonsson, Björn. (2014). Psychodynamic Therapies with Infants and Parents: A Review of RCTs on Mother–Infant Psychoanalytic Treatment and Other Techniques.

*Psychodynamic psychiatry*. 42. 617-40. 10.1521/pdps.2014.42.4.617.

Stern, D. N. (1985). *The interpersonal world of the infant: Views from psychoanalysis and developmental psychology*. New York: Basic Books.

Swenson, C. (1998). Clinical social work's contribution to a social justice perspective. *Social Work*, 43, 527-536.

Walsh, J. (2013). *Theories for direct social work practice*. Stamford, CT: Cengage. Chapter 8.

Zeanah, P, Stafford B, Zeanah. (2005). *Clinical Interventions to Enhance Infant Mental Health: A Selective Review*. UCLA. National Center for Infant and Early Childhood Health Policy.