Published in final edited form as:

Infant Ment Health J. 2017 May ; 38(3): 434–442. doi:10.1002/imhj.21641.

“I’m opening my arms rather than pushing away:” Perceived benefits of a mindfulness-based intervention among homeless women and young children

Jeanne L. Alhusen, PhD, RN,

Associate Professor, University of Virginia School of Nursing

Carole Norris-Shortle, LCSW-C, LMFT, RPT-S,

University of Maryland School of Medicine

Kim Cosgrove, LCSW-C, and

Program Director, PACT’s Therapeutic Nurseries

Lauren Marks, MSW, LGSW

Abstract

Family homelessness is associated with adverse outcomes in mothers and their young children. Evidence-based programs are needed to support the socio-emotional needs of these families. The purpose of this qualitative study was to explore the perceived benefits of participating in a mindfulness program in mother-child dyads receiving services at a therapeutic nursery serving homeless children under the age of 3. A convenience sample of 17 predominantly African American mothers participated in in-depth qualitative interviews. Four themes were derived from the data regarding the perceived benefits of the mindfulness program including: “me” time, maternal self-regulation, dyadic connectedness, and child well-being. Results demonstrate the perceived benefits of mindfulness on the parent-child relationship, and have important implications for families at an increased risk of adverse outcomes. Because homelessness and residential instability confer considerable risk for young children, interventions to support effective parenting are critical.

Keywords

mindfulness; maternal sensitivity; homelessness; attachment

Family homelessness remains a significant public health issue associated with negative physical and mental health outcomes for those impacted. The impact of homelessness on children, particularly young children, includes an increased risk of poor mental health, socio-emotional problems, and cognitive delays (Shinn, Samuels, Fischer, Thompkins, & Fowler, 2015). The evident disparities in physical and mental health outcomes among homeless individuals are exacerbated by poor access to health care as well as difficulties in

medication adherence (Baggett, O'Connell, Singer, & Rigotti, 2010; Canavan et al., 2012; Coe et al., 2015; Hwang et al., 2010).

On any given night in the United States, more than 600,000 individuals are homeless; of these, nearly 25% of homeless individuals were children living in families (Fazel, Geddes, & Kushel, 2014). According to the Homeless Emergency Assistance and Rapid Transition to Housing Act's (HEARTH) recently amended definition that includes families that have precarious housing situations, an estimated 1.6 million children were homeless in the United States between 2011 and 2012, reflecting a 10% increase from the previous year (Bassuk, DeCandia, Beach, & Berman, 2014).

Homeless women experience disproportionately high rates of adverse physical and mental health outcomes including higher rates of depression (Bassuk & Beardslee, 2014). This is due, in part, to extreme poverty, exposure to violence, and limited social support networks (Weinreb, Buckner, Williams, & Nicholson, 2006). Compounding this issue is that services for homeless families are often directed toward housing and other essential services, and few resources are available to address the mental health needs of homeless mothers and their children.

The harmful effects of homelessness on children are well-documented. A recent systematic review examined the mental health needs and outcomes of homeless children finding that homeless children, as compared to housed children, experienced higher rates of mental health and behavioral problems. Specifically, 14% to 26% of homeless preschoolers and 24% to 40% of school-age children had mental health problems necessitating clinical evaluation (Bassuk, Richard, & Tsertsvadze, 2015). The rate of mental health problems noted in school-age children is 2 to 4 times higher than reported rates of mental health problems in poor children aged 6 to 11 noted in the National Survey of America's Families (Howell, 2004). Less researched is the impact of homelessness on infants and toddlers. Indeed, in a recent meta-analysis examining the prevalence of mental illness in homeless children, only one study focused on children less than three years of age finding no significant differences in developmental status between homeless and low-income house children. However, the younger children in both conditions performed better than the older children on most summary scores assessed by the Bayley Scales of Infant Development suggesting a cumulative effect of poverty on developmental outcomes (Bassuk et al., 2015). Further, children experiencing homelessness are typically exposed to multiple stressors including witnessing interpersonal and community violence, exposure to higher rates of maternal depression and other psychiatric disorders, parental substance use, and fewer educational, and social resources available to assist in mitigating their multiple risk factors (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013).

Taken together, the research literature supports an urgent need for evidence-based programs to support homeless families, particularly those with young children. The purpose of this study is to describe the perceived benefits of a mindfulness program that was implemented in a Therapeutic Nursery (TN) serving homeless children under the age of three and their caregivers.

Mindfulness

Mindfulness is defined as “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment by moment” (Kabat-Zinn, 2003, p.145). A sizeable body of literature supports that mindfulness is associated with greater self-efficacy, coping, and emotional regulation (Brown & Ryan, 2003; Keng, Smoski, & Robins, 2011). Further, mindfulness has been associated with improvements in physical and psychological well-being, including decreased symptoms of chronic pain, fatigue, and depression (Khoury, Sharma, Rush, & Fournier, 2015). Mindfulness research to date is largely focused on individual outcomes, yet a tenet of mindfulness is its benefits on interpersonal relationships via compassion for the self, which presumably leads to improved responsiveness to others (Kabat-Zinn, 2003). Limited research has supported the benefits of mindfulness on the parent-child relationship, yet its benefit on homeless mothers and children has been largely unexplored (Bazzano et al., 2015; S. M. Bogels, Lehtonen, & Restifo, 2010). Further, extant mindfulness research in children has largely been focused on preschool and school-aged children. An important gap in the literature is an understanding of the benefits of mindfulness in children under the age of three.

The SHINE mindfulness program is an innovative ten-session program that teaches research-based, mindfulness awareness practices to people living with poverty, homelessness, addictions, abuse and physical and mental health challenges. It has been utilized in the PACT Therapeutic Nursery, in conjunction with the Mindful Awareness Play (MAP) parent-child play activity, to promote mutual regulation, strengthen family attachments, and reduce stress and anxiety.

The carefully designed weekly activities are based on compelling scientific evidence that mindfulness can produce demonstrable positive effects on brain and immune function (Davidson et al., 2003). Specific elements are repeated each week for a predictable group structure to the group hour (i.e., review of group agreements, passing of a “talking stick” for individual comments, and sharing of mindful “victories” parents experienced in past week) Each week SHINE teaches, through carefully designed activities, the goals of the SHINE program (Support, Honor, Inspire, Nurture, Evolve). This is done through three formal guided meditations in each session. Additionally, each week an informal “Key to Mindfulness” practice is taught using interactive exercises, demonstrations and peer teachings. Each “Key” depicts a simple clear practice that focuses on the parent creating an intentional pause for self-reflection and wise choice. At the conclusion of the group the parent is given a nicely designed “Key” tag which corresponds to the mindful teaching for the day and can serve as a reminder in their pocket to use mindfulness to deal with their daily stresses.

Mindful Awareness Play

Mindful Awareness Play (MAP) is a play intervention used by clinicians at the TN with babies and parents to strengthen their attachment relationship, promote mutual regulation, and address trauma-induced developmental delays. During the MAP session, each dyad is

paired with a clinician and is seated on a bright blanket on the floor. The dyad is presented with a decorated red box containing a simple mystery item each week (e.g., peek-a-boo cloth, feathers, shaker). The clinician supports the parent to be the Curious Observer and follows the child's Curious Explorer lead. At first this can feel frustrating or unnatural for parents, but they quickly realize that following their child's lead creates a nurturing environment that allows their child's creativity, focus, and problem-solving skills to emerge.

An additional component of MAP is providing parents and very young children an opportunity to engage in interactive play which prompts curious exploration, free from expectation and judgement. This open space for exploration facilitates emotional connections between parents and their children. The MAPS play experience allows parents who have not experienced moment to moment non-judgmental play interaction a unique opportunity to build interactive patterns that can act as a protective factor for their young child's social emotional growth.

Methods

This qualitative study was part of a program evaluation that examined participants' perceptions of various components of the program. This report focuses on the mindfulness training participants received, both through the MAP and in the SHINE mindfulness program. A convenience sample of mothers attending PACT TN was recruited between July 2013 and March 2015. Institutional Review Board approval was received from Johns Hopkins Medical Institution.

Procedures

Program participants were invited to participate in an exit interview within a month of their program completion. After obtaining participants' permission, all interviews were video-recorded. Each of the interviews lasted approximately 30 minutes and was conducted within a private room in the TN. The individual interviews were conducted by graduate students who were not involved in the intervention. The interviews were guided by open-ended questions with relevant probes to assist participants as needed. The team developed the interview guide to elicit in-depth feedback on all program components with a focus on the perceived benefits of mindfulness. The questions specific to mindfulness included "Tell me how participating in the mindfulness sessions has helped you personally? Which mindfulness skills do you find most helpful in your own daily routine? How do you think participating in mindfulness has helped you as a parent? What changes have you noticed in interacting with your child(ren)? What differences, if any, do you notice in how your child responds to you?" For many of the questions, participants were encouraged to provide a specific example.

While each interview followed a topical outline, the experiences of each participant varied across interviews based on participant's experiences with the program. The interviewer was flexible during the interviews, allowing participants to tell their stories, probing only for clarification. Upon the completion of each interview, participants were compensated with a small stipend for their time and expertise.

The video-taped interviews were digitally recorded and then transcribed verbatim. Each transcript was read though several times, and reviewed for accuracy by study team members who conducted the individual interviews. Analysis of the qualitative data was conducted through a four-step process (Hsieh & Shannon, 2005). Constant comparison within and across interview transcripts was continually undertaken to develop and refine categories throughout the analytic process by three study team members (Hsieh & Shannon, 2005). Initially, three research team members independently read all of the transcribed interviews to immerse ourselves in the participants' responses. Next, the authors coded the individual interview transcripts with attention focused on the participants' discussion of mindfulness. This coding process included notes regarding the authors' first impressions as well as initial analysis. During the third step, the authors discussed emerging categories and themes in an iterative manner, establishing similar categories between coders. Lastly, using the themes or categories identified by all reviewing authors, interviews were independently reanalyzed by each of the authors. In any instances of contradiction, discussion among the authors continued until consensus was reached.

Results

Seventeen mothers participated in the qualitative interviews, and maternal age ranged from 24–44 with a mean age of 30.9 ($SD=5.4$). The majority of the mothers (71%) self-identified as African American, with the remaining mothers self-identifying as white. With regards to education, 5 (29%) mothers reported not completing high school, 4 (24%) completed high school, 6 (35%) completed “some” college, and 2 (12%) mothers received an Associate's or Bachelor's degree. At the time of the interview, the majority of mothers (65%) were living in shelters, and the remaining mothers reported being in unstable housing (17.5%) or transitional housing (17.5%). While many mindfulness-based stress reduction programs are comprised of eight sessions, in the current study there was no limit on the number of sessions mothers could attend. On average, women attended 5.6 mindfulness training sessions which included both the SHINE and MAP intervention. Each session lasted approximately one hour.

Participants shared common perceptions about how participating in the mindfulness program helped them personally. Each participant discussed how the program improved their relationship with their child(ren), and the majority of the participants noted positive changes in their young children's behavior. Four themes were derived from the data regarding the perceived benefits of the mindfulness program including: “me” time, maternal self-regulation, dyadic connectedness, and child well-being. These themes were quite interrelated with participants attributing changes in their children's behavior to changes in their own behavior.

“Me” Time: “Take that moment and just be with myself”

Each of the participants discussed an enhanced appreciation of allowing themselves to take a few minutes each day to focus on themselves, often described as “me” time. Many of the participants discussed that this was not something that they had ever done before, but noted immediate benefits in allowing themselves to take a few minutes “to take that time for

myself.” In taking this time participants noted that they were able to deal with particular stressors more effectively. One participant noted to her family that, “mommy needs a ‘me’ time moment so now I can close the door, take a deep breath, and then come back.” Prior to participating in the mindfulness program, this participant commented that she would have reacted quickly, and often negatively, without allowing herself time to “settle.” Similarly, another participant commented:

I learned how to stop and take a minute. Instead of reacting right away when [child] does something wrong, I take a minute to myself. Instead of yelling “leave mommy alone” I say give mommy a couple minutes to get herself together...I need to calm down and when I finish calming down I’ll call you over and we can talk about it.

This same participant attributed this technique to a significant change in her interactions with others, and remarked that it substantially decreased the number of altercations she had with others. Many of the participants acknowledged that they had many “hurdles” in their lives due to their current living circumstances. One participant noted it was important to take that time for herself so that she could “handle everything one step at a time...so you can hear yourself so you can move on the next obstacle to get to your goal.” Similarly, another participant commented the program had been most beneficial in providing her “the ability to stop for a moment and breathe and say everything is going to be okay.” Consistent with the tenets of mindfulness, the ability to take a few minutes each day to be alone, and to “settle” their breathing, helped decrease the anxiety and perceived stress each participant expressed related to the various challenges they were experiencing.

Maternal self-regulation: “It’s not worth the drama”

Related to “me” time, each participant discussed how participating in the mindfulness program helped with regulating their behavior. Many of the participants contrasted reactions to current stressors with how they would have previously responded, often using phrases including “I would go from 0 to 10 in a second” or “I could go from being calm to totally frustrated...0 to 100 in a minute.” Many of the participants discussed the various stressors they were faced with, and how they thought stress was impacting them physically and emotionally. One participant noted:

The way I handle stress is different. I don’t let it consume me. I focus more on how can I improve this? How can I make this great? I don’t stress about the things I can’t change and control like I used to. It’s more like this is a test, this is a trial, let’s figure it out...which was nearly impossible for me to do before...I would stress about things I couldn’t do anything about instead of focusing on the things I could work on. It doesn’t consume me...I’m proud of myself for trying to make these changes.

Several participants remarked how stressful it was to rely on the city bus for transportation. The bus was often late making them miss appointments, or crowded making it difficult to use with children in tow. Many of the participants discussed examples of how mindfulness helped with the daily stress of riding the bus. One participant discussed being on the bus when the bus broke down. She was now going to be late for an appointment for her child, and she remarked “I remained calm. I took a moment to say it’s going to be okay...we’re

going to get there, and everything is going to be fine.” When asked if this was a change in how she would have previously responded she remarked “absolutely...complete opposite in a good way.” Another participant was discussing the stress of relying on the city bus, and said she can deal with the stress of the bus being late “a lot better now. I’ve learned to respond, and not to react.” Finally, a participant discussed an interaction she had with a neighbor who had not returned a stroller the participant had lent her. The participant asked her neighbor on several occasions to return the stroller, and the neighbor finally “exploded” on the participant screaming expletives. The participant stated “I kept my cool, I didn’t yell, I didn’t scream...Can I have my stroller please? Thank you.” The participant said prior to participating in the mindfulness program this type of interaction would have likely ended up becoming physical.

With regards to self-regulation, many of the participants discussed improved regulation in response to their children’s behavior. One participant with several young children discussed how much more patience she had with her child:

She [daughter] has tantrums and sometimes her behavior is on a downward slope... it would aggravate the mess out me. I was like a ticking time bomb every time. I’ve learned to have more patience with her [child]. I always take time out to listen to my [tingsha] bells before I say anything so I’ll say something to her in a positive way rather than a negative way.

Another participant contrasted how she responded to her now 13 year old son when he was a young child with how she now responds more calmly to her young daughter, crediting mindfulness with the change in her response:

If one of my boys gets in trouble at school I’m not just going to jump to conclusions and punish them. I’m going to talk to them and find out what was going on in their head and why it happened. I’m not saying they won’t get punished, I just want to understand where their mind was at when they did it. And I want to talk about it which is not the mother I was for my 13 year old. I would just punish him...I never would have asked him why.

Maintaining a mindful awareness allowed participants to exercise a choice in their response to various situations. Many participants drew upon previous “automatic” reactions with their children, and discussed how avoiding automatic reactions provided more enjoyment in the parent-child relationship.

Dyadic Connectedness: “I’m opening my arms rather than pushing away”

Each of the participants addressed how the mindfulness program improved their relationship with their child(ren). Many participants specifically explained how the program allowed them to view situations from the perspective of their child, thereby allowing them to gain a better understanding of their child’s feelings. One participant discussed a situation where her daughter was having trouble sleeping in a shelter, she stated:

It [the program] put a new perspective on things because I was looking at it as what I have done, it was more about me. But when I took a step back and put myself in her shoes I could see things completely differently.

Similarly, another participant commented, “He [son] has feelings too...you have to help them learn how to deal with their feelings sometimes too...you know help them get through it just like you try to help yourself get through it.”

Additionally, many participants expressed how the mindfulness program helped improve parent-child communication. In regards to their children misbehaving, one participant stated:

If they are not listening or they are not behaving or whatever, for me to kind of get on their level and make sure that they are looking at me, and discuss it, not just ‘no’, punish them, holler, whatever. Try to take a step in between all that, and kind of explain and make sure they fully understand.

The same participant also added “It’s not always what you say, but how you say things.” Several participants also included how they now utilize mealtime as a time to communicate and be with their children. One participant commented:

To engage during mealtime, to talk about the food that’s on their plate, and make any type of conversation just to engage. Don’t just sit there in silence or watching TV or me on my cell phone. You might be eating dinner together, but you’re not eating dinner *together*.

A majority of participants also acknowledged how they enjoyed and were more appreciative of the time they spent with their children more after completing the mindfulness program. When discussing playtime, one participant stated, “I’m opening my arms rather than pushing away.” Another participant commented, “She [daughter] felt that she had my complete, undivided attention. It’s comforting, it feels nice. It’s kind of a happy moment.” Multiple participants also remarked about interactions with their children such as “I started paying more attention,” “I now let my child take the lead,” and “my child makes me laugh more.” Overall, by utilizing the concepts learned and practiced throughout the mindfulness program participants were able to improve their relationship with their children by displaying greater attunement, improved communication, and more appreciation for the time they spent with their children.

Child well-being: “It’s my temperament that’s calming him down”

In the interviews the participants discussed how their children’s behavior and well-being had been positively influenced through their own participation in the mindfulness program. The participants mentioned several different types of positive child outcomes, including improved behavior, communication, attachment and mental health within their children. Many of the participants discussed how their ability to self-regulate their emotions and behaviors influenced similar positive changes in their children.

Participants repeatedly discussed how their child’s communication patterns had increased and become more age appropriate and clear. One mother said “I showed her [child] other ways of how to get my attention without having to throw stuff at me or kick me or force her toys on me.” Another participant noted that “He’s [child] sitting more and paying attention.” Prior to participating in the mindfulness program many of the participants expressed concern that their children were unable to communicate their needs, and after participating one

mother said, “with the potty situation, now she’ll actually tell me when she needs to go” and the father agreed, “Yes, she talks more now.”

Participants also noted that their children seemed to want to be physically and emotionally closer to them after their participation in the mindfulness program. One participant noted “She listens more. We seem more connected.” This increased connectedness can be seen as a sign of secure attachment and positive bond between parent and child. Another participant said, “I feel like she’s also reaching out to mommy and like, letting me, include me into her playtime.” One participant with several young children said “Being that I’m able to incorporate mindfulness, and the things that I’ve learned in the group, into my life-it’s, (like) they’re drawing back into mom/me, like every day my child makes sure she’s on my lap just to be here.” This increased physical and emotional closeness and connectedness was often noted after the parent and child participated in the MAP sessions. One mother noted that her child “...felt that she had my complete undivided attention.”

Many of the participants also mentioned that they noticed changes in their child’s behavior that they felt were indicative of improved mental health. One participant commented “you don’t really think that a two or three year old is learning adult coping skills but they are,” further discussing that her child was learning skills that she had learned through the mindfulness program. Similarly, another participant noted:

When I started they would ask me “Mommy where are you going?” I’d be like “Mommy just needs to take a breath for a few minutes” and before I know it my little boy...three years old, saw me getting upset and said “Mommy I think you should go take a breath”, and then the very next week he got all upset and he said “Mommy I think I need to take a breath.”

Participants showed pride and happiness in response to their children exhibiting these behaviors. One participant said “that makes me feel good” when she realized that her child’s stutter had “gone down tremendously” which she attributed to her own improved temperament. Another participant discussed the positive changes she was observing in her young child and remarked, “It’s awesome because it makes me feel like I’m doing the right thing you know, that I’m being a good parent.”

Discussion

The goal of this study was to further our understanding of mindfulness, and its perceived benefits among a highly vulnerable sample. Findings from the current study provide further evidence of the benefits of mindfulness with participants noting benefits on their health, parenting, and consequently, their young children’s behavior.

Participants described an improvement in their own health, and subsequently their parenting abilities, in part due to allowing themselves time to focus on themselves. A mother’s ability to take care of herself while simultaneously caring for her child is key to positive parenting. Findings from the current study are consistent with other research examining mindful parenting. Mindful parenting interventions, based on the tenets of mindfulness, have shown improvements in parental anger management as well as reductions in disagreements between

parents (S. M. Bogels et al., 2010; Coatsworth, Duncan, Greenberg, & Nix, 2010; Dawe & Harnett, 2007). In a clinic-based sample of young children with emotional and behavior problems, self-reported mindfulness was associated with improved parenting behaviors (Williams & Wahler, 2010). The benefits of mindfulness may be particularly salient for homeless families who may have greater difficulty providing themselves with “self-nurturing” “attention due to the multiple stressors inherent with homelessness. Through the SHINE program, participants learned to allow themselves time for self-compassion. This balance between attention to oneself, and attention to one’s child is requisite for positive parenting. Indeed, improved self-compassion may have improved participant’s compassion towards their own children, particularly in historically stressful situations. While mindfulness research to date has largely focused on outcomes for the individual, Kabat-Zinn (1991) suggest that interpersonal relationships are improved through mindfulness via improved self-compassion which ultimately improves one’s responsiveness to others.

Each participant described stressors that they were facing, and attributed mindfulness to decreased stress and improved self-regulation. There are well-established links between parenting stress and parenting skills; that is, under increased stress parents often become more controlling, more reactive, and less warm towards their children (Piehler, Lee, Bloomquist, & August, 2014). Research has demonstrated that cumulative “life” stress and parenting stress independently predict less maternal positivity in interactions with their young children, and parenting stress is also predictive of less pleasure in parent-child dyads (Mantymaa et al., 2015). Consistent with these findings, participants in the current study described more joy in their interactions with their young children which they attributed to participating in mindfulness. There are well-established links between parenting stress and early child outcomes, and this association may be attenuated in homeless families who face more economic hardships and have insufficient supports in place.

Few studies have examined the effects of parental mindfulness on early childhood outcomes. Consistent with the current study’s findings, published research suggest that improved parental mindfulness is associated with a range of positive child outcomes. A recent study conducted among a large sample of parents and their children, aged 3–17 years, found that higher levels of parental dispositional mindfulness were indirectly associated with lower levels of youth internalizing and externalizing problems via higher levels of mindful parenting and less negative parenting practices. Notably, the sample was largely white, married, and well-educated (Parent, McKee, N Rough, & Forehand, 2015). In a Dutch sample of perinatal women, higher maternal mindfulness during pregnancy was associated with less infant self-regulation problems and less infant negative affectivity at ten months of age (van den Heuvel, Johannes, Henrichs, & Van den Bergh, 2015). While limited, research supports the role of mindfulness in improved childhood outcomes. Participants in the current study attributed positive changes in their children’s behavior to their own participation in mindfulness training. There are multiple pathways by which mindfulness may be associated with childhood outcomes, and in the current study the majority of participants discussed stress reduction as one such pathway. Indeed, the preponderance of support for mindfulness training has been derived from studies examining its effects on parental stress among parents of children with developmental delays, socioemotional disorders, ADHD, and receiving

special education (Benn, Akiva, Arel, & Roeser, 2012; S. Bogels, Hoogstad, van Dun, de Schutter, & Restifo, 2008; Singh et al., 2007; van der Oord, Bogels, & Peijnenburg, 2012).

Homelessness and residential instability are significant risk factors for adverse childhood outcomes. The parent-child relationship is the most salient moderator of the relationship between children experiencing homelessness and early childhood outcomes. Thus, interventions to reduce stress thereby improving the parent-child relationship are needed, particularly for very young children. Findings from the current study suggested mindfulness as a promising strategy to support the socioemotional development of young children.

There are several limitations of the current study that should be noted. First, the sample was limited to homeless parents and their young children receiving services at an urban therapeutic nursery thus results are not generalizable to other populations. Second, all data was self-report, and future studies should include more objective measures of mindfulness as well as parent-child interaction. Finally, the qualitative interviews were conducted at a single time point, and future studies should incorporate longitudinal designs to best illuminate causal inferences. Nonetheless, to our knowledge, this is the first study to explore the perceived benefits of mindfulness on parental and childhood outcomes in a high-risk sample of parents with very young children.

Implications for Practice

Results from the current study add to a growing body of research on the benefits of mindfulness on the parent-child relationship, and have important implications for families at an increased risk of adverse outcomes. Because homelessness and residential instability are associated with considerable risk for young children, interventions to support effective parenting are critical. Teaching parents to be mindful in their daily interactions with their young children may be one avenue to improving the quality of the parent-child relationship while fostering the socioemotional growth of very young children. Key to realizing these outcomes is helping parents practice mindful self-regulation and self-compassion given their benefits on emotional regulation. The concept of self-compassion is particularly important for homeless parents who are confronted with many stressors that often take precedence over their own well-being. By giving the parent the opportunity to practice these skills with their child within the weekly relationship-based program at the TN, the quality of the parent-child interaction is enhanced. Further, parents are supported in incorporating these same skills in their activities outside of the TN.

There is a significant body of research that discusses risk factors that compromise effective parenting in homeless individuals (Buckner, 2008; Gewirtz, DeGarmo, Plowman, August, & Realmuto, 2009; Park, Ostler, & Fertig, 2015). Less studied are the promotive and protective factors that support competent parenting in highly adverse environments (Narayan, 2015). Limited research, owing largely from resilience literature, suggests that positive parenting in homeless individuals is facilitated when individuals possess effective strategies to reduce the stress (Narayan, 2015). Our results demonstrate that the experience of homelessness, while highly stressful, does not prevent improved parental functioning.

Family homelessness is a significant public health issue with myriad adverse outcomes for children and parents. If young children are exposed to supportive, nurturing relationships, the deleterious effects of homelessness and its related indicators may be attenuated. Our research demonstrates that a mindfulness intervention may foster the development of positive parent-child interaction.

Acknowledgments

Human subjects approval for this study was received from Johns Hopkins Medical Institution.

This research was supported by funding from the National Institute of Nursing Research (K23NR015810).

References

- Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. The unmet health care needs of homeless adults: A national study. *American Journal of Public Health*. 2010; 100(7):1326–1333. DOI: 10.2105/AJPH.2009.180109 [PubMed: 20466953]
- Bassuk, EL., DeCandia, J., Beach, C., Berman, F. America's youngest outcasts: A report card on child homelessness. The National Center on Family Homelessness, American Institutes for Research; 2014.
- Bassuk EL, Beardslee WR. Depression in homeless mothers: Addressing an unrecognized public health issue. *The American Journal of Orthopsychiatry*. 2014; 84(1):73–81. DOI: 10.1037/h0098949 [PubMed: 24826830]
- Bassuk EL, Richard MK, Tsertsvadze A. The prevalence of mental illness in homeless children: A systematic review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2015; 54(2):86–96.e2. DOI: 10.1016/j.jaac.2014.11.008 [PubMed: 25617249]
- Bazzano A, Wolfe C, Zylowska L, Wang S, Schuster E, Barrett C, Lehrer D. Mindfulness based stress reduction (MBSR) for parents and caregivers of individuals with developmental disabilities: A community-based approach. *Journal of Child and Family Studies*. 2015; 24:298–308.
- Benn R, Akiva T, Arel S, Roeser RW. Mindfulness training effects for parents and educators of children with special needs. *Developmental Psychology*. 2012; 48(5):1476–1487. DOI: 10.1037/a0027537 [PubMed: 22409766]
- Bogels S, Hoogstad B, van Dun L, de Schutter S, Restifo K. Mindfulness training for adolescents with externalizing disorders and their parents. *Behavioural and Cognitive Psychotherapy*. 2008; 36:193–209.
- Bogels SM, Lehtonen A, Restifo K. Mindful parenting in mental health care. *Mindfulness*. 2010; 1(2): 107–120. DOI: 10.1007/s12671-010-0014-5 [PubMed: 21125026]
- Brown KW, Ryan RM. The benefits of being present: Mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*. 2003; 84(4):822–848. [PubMed: 12703651]
- Buckner JC. Understanding the impact of homelessness on children: Challenges and future research directions. *American Behavioral Scientist*. 2008; 51:721–736.
- Canavan R, Barry MM, Matanov A, Barros H, Gabor E, Greacen T, ... Priebe S. Service provision and barriers to care for homeless people with mental health problems across 14 European capital cities. *BMC Health Services Research*. 2012; 12:222-6963-12-222.doi: 10.1186/1472-6963-12-222 [PubMed: 22838503]
- Coatsworth JD, Duncan LG, Greenberg MT, Nix RL. Changing parent's mindfulness, child management skills and relationship quality with their youth: Results from a randomized pilot intervention trial. *Journal of Child and Family Studies*. 2010; 19(2):203–217. DOI: 10.1007/s10826-009-9304-8 [PubMed: 24013587]
- Coe AB, Moczygemba LR, Gatewood SB, Osborn RD, Matzke GR, Goode JV. Medication adherence challenges among patients experiencing homelessness in a behavioral health clinic. *Research in Social & Administrative Pharmacy : RSAP*. 2015; 11(3):e110–20. DOI: 10.1016/j.sapharm.2012.11.004 [PubMed: 23218849]

- Davidson RJ, Kabat-Zinn J, Schumacher J, Rosenkranz M, Muller D, Santorelli SF, ... Sheridan JF. Alterations in brain and immune function produced by mindfulness meditation. *Psychosomatic Medicine*. 2003; 65(4):564–570. [PubMed: 12883106]
- Dawe S, Harnett P. Reducing potential for child abuse among methadone-maintained parents: Results from a randomized controlled trial. *Journal of Substance Abuse Treatment*. 2007; 32(4):381–390. S0740-5472(06)00335-7. [PubMed: 17481461]
- Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: Descriptive epidemiology, health consequences, and clinical and policy recommendations. *Lancet (London, England)*. 2014; 384(9953):1529–1540. DOI: 10.1016/S0140-6736(14)61132-6
- Gewirtz AH, DeGarmo DS, Plowman EJ, August G, Realmuto G. Parenting, parental mental health, and child functioning in families residing in supportive housing. *The American Journal of Orthopsychiatry*. 2009; 79(3):336–347. DOI: 10.1037/a0016732 [PubMed: 19839671]
- Grant R, Gracy D, Goldsmith G, Shapiro A, Redlener IE. Twenty-five years of child and family homelessness: Where are we now? *American Journal of Public Health*. 2013; 103(Suppl 2):e1–10. DOI: 10.2105/AJPH.2013.301618
- Howell, E. Access to children's mental health services under medicaid and SCHIP. *New Federalism, National Survey of America's Families*, the Urban Institute; 2004. No. Series B, No. B-60
- Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qualitative Health Research*. 2005; 15(9):1277–1288. DOI: 10.1177/1049732305276687 [PubMed: 16204405]
- Hwang SW, Ueng JJ, Chiu S, Kiss A, Tolomiczenko G, Cowan L, ... Redelmeier DA. Universal health insurance and health care access for homeless persons. *American Journal of Public Health*. 2010; 100(8):1454–1461. DOI: 10.2105/AJPH.2009.182022 [PubMed: 20558789]
- Kabat-Zinn J. Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*. 2003; 10:144–156.
- Keng SL, Smoski MJ, Robins CJ. Effects of mindfulness on psychological health: A review of empirical studies. *Clinical Psychology Review*. 2011; 31(6):1041–1056. DOI: 10.1016/j.cpr.2011.04.006 [PubMed: 21802619]
- Khoury B, Sharma M, Rush SE, Fournier C. Mindfulness-based stress reduction for healthy individuals: A meta-analysis. *Journal of Psychosomatic Research*. 2015; 78(6):519–528. S0022-3999(15)00080-X [pii]. [PubMed: 25818837]
- Mantymaa M, Puura K, Luoma I, Latva R, Salmelin RK, Tamminen T. Shared pleasure in early mother-infant interaction: Predicting lower levels of emotional and behavioral problems in the child and protecting against the influence of parental psychopathology. *Infant Mental Health Journal*. 2015; 36(2):223–237. DOI: 10.1002/imhj.21505 [PubMed: 25739800]
- Narayan AJ. Personal, dyadic, and contextual resilience in parents experiencing homelessness. *Clinical Psychology Review*. 2015; 36:56–69. DOI: 10.1016/j.cpr.2015.01.005 [PubMed: 25687153]
- Parent J, McKee LG, Rough NJ, Forehand R. The association of parent mindfulness with parenting and youth psychopathology across three developmental stages. *Journal of Abnormal Child Psychology*. 2015; doi: 10.1007/s10802-015-9978-x
- Park JM, Ostler T, Fertig A. Physical and psychological aggression towards a child among homeless, doubled-up, and other low-income families. *Journal of Social Service Research*. 2015; 41(3):413–423. DOI: 10.1080/01488376.2015.1018660 [PubMed: 27134322]
- Piehler TF, Lee SS, Bloomquist ML, August GJ. Moderating effects of parental well-being on parenting efficacy outcomes by intervention delivery model of the early risers conduct problems prevention program. *The Journal of Primary Prevention*. 2014; 35(5):321–337. DOI: 10.1007/s10935-014-0358-z [PubMed: 25037843]
- Shinn M, Samuels J, Fischer SN, Thompkins A, Fowler PJ. Longitudinal impact of a family critical time intervention on children in high-risk families experiencing homelessness: A randomized trial. *American Journal of Community Psychology*. 2015; 56(3–4):205–216. DOI: 10.1007/s10464-015-9742-y [PubMed: 26238278]
- Singh NN, Lancioni GE, Winton AS, Singh J, Curtis WJ, Wahler RG, McAleavey KM. Mindful parenting decreases aggression and increases social behavior in children with developmental disabilities. *Behavior Modification*. 2007; 31(6):749–771. 31/6/749 [pii]. [PubMed: 17932234]

- van den Heuvel MI, Johannes MA, Henrichs J, Van den Bergh BR. Maternal mindfulness during pregnancy and infant socio-emotional development and temperament: The mediating role of maternal anxiety. *Early Human Development*. 2015; 91(2):103–108. DOI: 10.1016/j.earlhumdev.2014.12.003 [PubMed: 25577496]
- van der Oord S, Bogels SM, Peijnenburg D. The effectiveness of mindfulness training for children with ADHD and mindful parenting for their parents. *Journal of Child and Family Studies*. 2012; 21(1): 139–147. DOI: 10.1007/s10826-011-9457-0 [PubMed: 22347788]
- Weinreb LF, Buckner JC, Williams V, Nicholson J. A comparison of the health and mental health status of homeless mothers in Worcester, Mass: 1993 and 2003. *American Journal of Public Health*. 2006; 96(8):1444–1448. AJP.2005.069310 [pii]. [PubMed: 16809590]
- Williams KL, Wahler RG. Are mindful parents more authoritative and less authoritarian? An analysis of clinic-referred mothers. *Journal of Child and Family Studies*. 2010; 19:230–235.