Families with young children visit pediatric primary care providers regularly, expecting answers to questions about their young child’s health and development. Although physical health is of utmost importance in infancy and early childhood, it is inextricably connected to children’s psychosocial development and functioning. Understanding the whole child, developmentally, medically, biologically, psychologically, socially, and culturally allows for an integrated, “biopsychosocial” (Kazak, Simms, & Rourke, 2002, p. 134), and cultural perspective of a child and family.

Families of babies and young children turn more frequently to their health care providers than to other specialists for information regarding parenting and child development (Inkelas, Glaesce, et al., 2002; Inkelas, Schuster, Newacheck, Olsen, & Halfon, 2002). Integrating an infant–early childhood mental health and child development specialist into a pediatric primary care setting provides additional supports and resources to families with young children (Talmi, Stafford, & Buchholz, 2009). The integrated clinician expands the nature and content of pediatric visits by including topics that might otherwise not be discussed (e.g., postpartum depression, breastfeeding, sleep routines, behavior concerns, and sibling adjustment; Buchholz & Talmi, 2012). Integrated clinicians also enhance families’ relationships with their primary care providers and promote a medical home approach (Stille et al., 2010).

The following narrative illustrates the first author’s experience as an infant mental health and developmental specialist providing integrated behavioral health and developmental services in a high volume, high-need, and low-resource pediatric primary care clinic in Colorado. The cases that follow represent experiences with young children and their families during a morning in clinic. All names and identifying information have been changed to protect patient confidentiality.

8:30 A.M.: The Twins

I arrived to clinic early, checked the schedule, and immediately recognized the first appointment of the day. The Brown twins were scheduled for their 2-month well-child check. I first met Kylie and Cole when they were 2 weeks old during their second newborn visit. At that visit, their primary care provider (PCP) expressed concern about their mother’s parenting abilities because she had a history of substance abuse during her pregnancy. The PCP requested that I attend the visit to assess parent and child safety and address concerns. I introduced myself to the family—the twins and their parents, Sandra and Rod—and explained my role in the clinic as providing additional developmental and mental health support to children and families. I explored Sandra’s experience of pregnancy, whether the pregnancy was planned, and what her feelings about having children were. I also asked Sandra if she felt comfortable discussing her history of substance use. Sandra nodded, shared that she struggled with cocaine use throughout her life, and disclosed that she was currently “clean” and had attended Narcotics Anonymous.

Abstract

Families with young children attend well-child visits in pediatric primary care settings frequently during the first 3 years of life and receive information and answers to questions about their young child’s health and development. Integrating an infant–early childhood mental health and child development specialist into a pediatric primary care setting provides additional supports and resources to families with young children. This article describes the families seen by a developmental specialist working in an urban primary care clinic serving high-risk, low-income families during one morning in clinic. The diversity and complexity of infant mental health and developmental issues brought by families to their pediatric providers and the value of seeking reflective supervision for integrated clinicians are highlighted.
during her pregnancy. She also disclosed that family violence had triggered past substance use. I looked at Rod, and Rod looked at the floor. Rod shared that he had an “anger management problem” and openly stated that he had a history of physically abusing Sandra when he was angry. We spent 15 minutes discussing specific interventions for eliminating family violence and brainstormed how these parents (who were not together) planned to coparent and raise twin babies.

Rod’s mother, Janice, the babies’ paternal grandmother, attended today’s 2-month visit with Sandra, Kylie, and Cole. Kylie was lying on the exam table, and Janice watched her lovingly while Cole slept soundly in his car seat. They had grown since I’d last seen them. Sandra’s eyes lit up as I knocked and entered the room, and she expressed that she had hoped to meet with me and was eager to discuss the twins’ latest accomplishments and the family’s changes. Kylie and Cole had not yet seen the medical provider, so I sat with Sandra and Janice to talk about the twins’ developmental accomplishments. Sandra shared that Cole was less fussy than he had been as a newborn and that he was eating “like crazy.” Kylie loved to be held and sung to. Sandra reported being worried about Cole’s upcoming surgery to repair a hernia, which led to a conversation about her anxiety and a plan to help her cope on the day of his operation. We enlisted Janice’s help in caring for Kylie so that Sandra could take Cole to the hospital alone.

Sandra and Rod had decided not to try to reconcile or coparent, so Sandra was now living alone with the twins with help from Rod’s mother for child care. Sandra reported that she had returned to Narcotics Anonymous and was clean and sober. She appeared happy, confident in her parenting, and connected to the babies. Janice expressed her support for Sandra and shared that she was helping Sandra financially with daily expenses and providing support with child care when she could.

Sandra shifted the discussion to child care because she was preparing to return to school to complete her high school degree. We discussed her ambivalence about returning to school full-time and leaving the twins in a child care setting. Sandra was working with Temporary Assistance for Needy Families, and together we drafted a letter to her caseworker, requesting that the program fund a family day care setting. Sandra was working with a part-time school option that would allow her to stay home with the twins 2 days a week.

As my visit with Sandra concluded, the PCP entered to complete the twin’s physical exam. I shared Sandra’s worry about the hernia operation with the provider and mentioned Sandra’s plans to return to school. Sandra agreed to schedule her next appointment on a day when I was in clinic.

9:15 A.M.: Sophia

Sophia, a 9-month-old, arrived in clinic with her mother Maria, an 18-year-old Puerto Rican first-time mother. The PCP requested that I meet with the family because Maria expressed worries about Sophia’s sleep difficulties and disclosed financial stressors. When I entered the room, I saw a young, tired, and overwhelmed mother and an alert, plump, smiling baby in a stroller. Initially, I spoke in English and explained my role as an integrated clinician and developmental specialist. Maria smiled faintly and stated, “Everything’s fine, we’re just a little short on money, and the baby won’t sleep through the night.” I paused and asked Maria in Spanish where she was from. Maria smiled, looked up, and began to tell me her story.

She and her boyfriend immigrated to the United States to pursue their educations. Maria wanted to attend school to become a veterinary technician, and her boyfriend studied graphic design. Maria’s father paid their way and their rent, until they arrived in the United States and learned that they were pregnant, unplanned and out of wedlock. Because of his strong Catholic religious and cultural beliefs about marriage, Maria’s father stopped supporting them financially, so Maria could no longer afford school. Her boyfriend, Sophia’s father, found employment during the day, and he studied and attended graphic design school at night. Maria began to cry as she explained how her dreams of working with animals and living in the United States were crushed when Sophia was born. The family faced having to move back to Puerto Rico because they could no longer afford their apartment.

I sat with Maria as she shared her story and her concerns about the future. Sophia, who had been sitting calmly, playing in her car seat, suddenly began to fuss. Maria looked at me and said, “She’s hungry,” and looked at the door as if to say they had to go so Sophia could eat. I asked if Maria had formula, and she nodded. I offered to fill up the bottle so that we could continue to talk, and Maria was surprised, “You don’t have to see another patient?” I explained that I could stay as long as she needed. While holding Sophia in her arms and feeding her, Maria began to describe her sleeping difficulties.

Maria explained that within the past 2 months Sophia had begun to awaken several times in the night (a change from her previous sleeping pattern). As we explored Maria’s concerns, I learned that Sophia slept in a pack-and-play in the second room of the family’s two-room apartment. We discussed sleep hygiene for infants and creating a positive bedtime routine, and I suggested some calming activities to try before bedtime with Sophia. I decided to ask some other questions about what occurs during the night and if anything had changed in the last 2 months in their apartment. Maria said, “Well, her dad just started taking online classes, so he’s up during the night on the computer in the same room as Sophia.” Maria shared that she was

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still getting up with Sophia at night, because once her boyfriend went to sleep, he was “out like a rock” and did not wake up with Sophia. Together, Maria and I explored how this dynamic might affect Sophia’s sleep and Maria’s feelings about parenting. Maria was resentful of her boyfriend, and Sophia’s sleep was being disrupted by the computer and his work during the night. Together, we developed a plan to share with Maria’s boyfriend, and Maria decided to try bringing the pack-and-play into the bedroom to decrease Sophia’s awakenings.

Before I had even addressed Maria’s financial concerns or provided referrals or resources, Maria began speaking in English, gathering her belongings and placing Sophia in her stroller. She thanked me and agreed to call me in the clinic with other questions or concerns.

9:45 A.M.: Isaiah

Isaiah, a 1-month-old premature infant (born at 31 weeks gestation), arrived for his first outpatient well-child check following his discharge from the neonatal intensive care unit. Isaiah’s PCP requested a consultation because of concerns about maternal depression that surfaced with an elevated screening score on the Edinburgh Postpartum Depression Screen (Cox, Holden, & Sagovsky, 1987).

I opened the door and glimpsed a tiny baby wearing a hat, swaddled tightly and being rocked gently by his mother who did not look up as I entered. Isaiah looked even smaller next to his heavy-set grandmother, Renee, who sat beside them. I approached Isaiah’s mother, Shaquice, and pulled up a stool close to her and her baby. As I introduced myself and began asking questions, Shaquice avoided eye contact and quietly stated, “It has been hard and not what I expected.” Shaquice shared that she and her husband had expected her pregnancy to last 40 weeks and to have a strong, healthy baby boy. She expected to breastfeed, as Renee had done with Shaquice and her twin sister, and she expected to feel happy about having a new baby.

Instead, Shaquice expressed feeling overwhelmed by how small and “fragile” Isaiah was and described intrusive thoughts about something bad happening to Isaiah. She feared that she might trip and fall down the stairs while holding him or that he might fall out of his car seat. I gently probed for symptoms of a pregnancy-related mood disorder and explored Shaquice’s anxiety about parenting a premature infant. I listened to her experience of lost expectations.

As the conversation unfolded, Shaquice also shared a sense of disappointment that breastfeeding had been challenging. Renee added how different her experience of breastfeeding was, compared to Shaquice’s, and how easy it had been to breastfeed her own twin girls. Isaiah’s grandmother could not understand why it was so difficult for Shaquice and Isaiah. Although Isaiah was born prematurely and not able to breastfeed immediately, he had begun to latch and was now able to breastfeed for about half of his feedings but not without significant difficulty and discomfort for Shaquice. As the theme of breastfeeding and the multigenerational dynamics unfolded, I suggested that Shaquice might find a lactation consultation helpful. Isaiah began to fuss, and Shaquice looked to Renee anxiously for support, but she appeared to read his cues appropriately and reached for a bottle of breast milk in her diaper bag. She settled in to bottle-feed him and he comforted quickly. As she fed Isaiah, Shaquice and Renee began to ask more questions about child development. They both shared their observations about Isaiah’s sensory sensitivities, noting that he cries a lot during bath time and diaper changes, gets hiccups regularly, and falls asleep only when held and swaddled.

First, I praised Shaquice (and her husband, who was at work), for their good instincts and observations of Isaiah’s personality, likes, and dislikes since being home. I also discussed some general information about the development of premature babies and their sensory sensitivities. Isaiah’s hiccups became a signal that he was feeling overwhelmed or having trouble handling what was happening around him. I asked Shaquice to imagine that Isaiah was still inside of her belly and to envision what it would feel like for him in there as compared what he was experiencing in the world outside. To demonstrate, I asked Shaquice and Renee to watch Isaiah as he drank from his bottle. Aloud, they observed that his eyes were squinted and almost closed and that his sucking was not rhythmic. I slowly turned out the lights in the exam room and asked Shaquice to describe the changes she noticed. She smiled and immediately observed that Isaiah’s eyes opened wider and he was able to make eye contact with her. She also observed that his sucking, swallowing, and breathing pattern became more regular.

We spent the remainder of the consultation discussing next steps, resources, and referrals for Shaquice and Isaiah. Shaquice denied any suicidal thoughts or thoughts of harming Isaiah but did identify feeling worried and afraid that something had might happen to him. She identified a strong social support network, including her husband and mother, and agreed to follow up with me in the next week to discuss resources for pregnancy-related mood disorder treatment if necessary. She also agreed to follow up with a lactation consultant to discuss her discomfort and distress and to receive the support she hoped to continue to successfully breastfeed Isaiah.

10:30 A.M.: Mohammed

Mohammed, a 16-day-old Iraqi baby boy came in for his 2-week well-child check. Mohammed’s PCP suspected that his parents were feeling overwhelmed but had difficulty assessing his
mother due to what the provider perceived as her “shy, quiet demeanor.” The PCP stated that Mohammed’s father seemed anxious and that the parents spoke very little English.

Pertinent developmental and medical history included Mohammed’s premature birth (34 weeks gestation) and recent discharge from the neonatal intensive care unit. The PCP reported a history of pregnancy loss and a maternal medical condition that resulted in a high-risk pregnancy, fetal distress, and preterm labor. At the time of the visit, Mohammed was reportedly medically healthy, breastfeeding well, and beginning to develop a sleep routine at home.

When I entered the exam room, Mohammed was lying calmly and quietly on the exam table, his father’s hand was resting protectively on his small body. His mother, dressed in a traditional burka with just her tired face showing, sat quietly across the room. Mohammed’s parents appeared sleep deprived, shaking hands and bowing their heads in introduction. I asked, “What has it been like for you to take care of Mohammed?” Mohammed’s father spoke slowly and was somewhat difficult to understand. He explained that the family moved to Denver at the beginning of pregnancy to receive medical care for Mohammed’s mother. They reported that they had no concerns about Mohammed except that they were both tired from waking up every 2 hours for feedings. They explained that they were very happy to welcome their first child, and they proudly showed me his small face and his full head of hair. Mohammed’s father explained that his son no longer needed oxygen to help him breathe.

Next, I moved my chair close to Mohammed’s mother and asked how she was feeling. A tear began to stream down her cheek as she spoke in broken English and said, “Very happy.” I asked Mohammed’s mother about her experience of pregnancy and if this had been her first pregnancy. Immediately, her tears of joy ceased. She began to use gestures to help me understand her. Moving her hands out in front of her stomach, she indicated that she had been pregnant before raising two fingers in the air. “Two years ago?” I asked. Mohammed’s mother responded, “Yes,” but also explained that it was a twin pregnancy. She then began to gesture expressively and used the few English words she had to illustrate her experience. Two babies. Two years ago. Lost. She pointed to her face, gestured tears of sadness, and showed babies coming out of her. “Bleeding,” she repeated, “Bleeding a lot.” Mohammed’s father sat quietly across the room, tearfully rocking his sleeping baby. He nodded in thanks and made eye contact with me as his wife told their story.

Together, Mohammed’s parents and I unfolded the family’s story of loss and, ultimately, their joy in welcoming a healthy baby to the world. I learned that the family came to the United States to find medical assistance so they could conceive and deliver safely after a traumatic loss 2 years ago. I obtained permission to speak with Mohammed’s mother’s physician to coordinate her care and refer her for mental health services to assist her and her husband in grieving their losses and parent their new baby.

11:15 A.M.: Ariana

As the morning rush began to subside, one of the PCPs asked me to see a family who was going to have a long wait. Because she had not yet seen the family, there were no identified behavioral health concerns. I planned to do a general developmental evaluation and use the Ages and Stages Questionnaire (ASQ-3; Squires, Twombly, Bricker, & Potter, 2009) as a tool to help me get to know 9-month-old Ariana. Ariana presented with her mother and father, Rina and Jesus, along with a 10-month-old brother and 3-year-old sister. I entered a loud, busy, and slightly crowded exam room filled with children’s voices in Spanish and English.

Ariana’s experienced parents had completed the developmental screener and were calmly managing their rambunctious, playful children as I introduced myself. When asked how they were all doing, Rina and Jesus responded positively in unison. They shared that they had no concerns about Ariana’s behavior or development, although they noticed and reported “sometimes” or “always” to some of the ASQ-3 items about Ariana’s language development and communication. When I reviewed and scored her ASQ-3, she scored in the “borderline” area for communication. As we discussed Ariana’s developmental history, I observed Ariana interacting with her siblings. She sat on her mother’s lap while her sister and brother tugged, poked, kissed, tickled, and talked to her. She giggled and buried her head in Rina’s chest when she appeared to be overwhelmed—all normative 9-month-old social behaviors.

Ariana’s parents and I reviewed the results of the ASQ-3 focusing on their responses to the questions in the Communication domain. Rina acknowledged that she does not always respond to simple commands and is not yet saying three words consistently. As we discussed her language development, Ariana’s parents and I observed her continued interaction with her siblings. Although the play was endearing, it also began to appear somewhat intrusive. Because Ariana did not appear distressed (as evidenced by fussing, crying, or resisting), Rina and Jesus were not concerned and did not intervene. I also observed that Ariana’s siblings were in the habit of talking for her and meeting her needs even before she had the opportunity to express herself. As we talked, Jesus gave Ariana his car keys to play with, and each time she threw them on the ground, following them with her gaze to the ground and beginning to pout, one of her siblings retrieved them. It was a game that perfectly illustrated a family dynamic that could have been contributing to Ariana’s slightly delayed language development.

Rina and Jesus shared that this pattern of behaviors between Ariana and her siblings happened regularly. Using their examples, we discussed ways in which to promote language development and create a list of new strategies to help and support Ariana’s development. I provided three books for the family—one for each child—and each adult (Rina, Jesus, and I) picked up a child in our laps and practiced reading aloud to the three children individually, engaging them at their independent developmental levels. Rina used animal sounds and lots of pointing while she read, and she allowed Ariana to mouth her board book. Jesus and Rina agreed to continue to practice this at home and to return for Ariana’s 12-month well-child check to reevaluate her communication and language development.

Reflective Supervision

This narrative depicts just one morning in clinic. In my experience as a clinical psychologist and infant mental health specialist working as a consultant in pediatric primary care, there are many mornings during which emotionally challenging cases emerge. Although the pace of the morning may vary (some mornings I see six patients, and some mornings I see only one), the profound impact the
families have on me personally does not lessen. The privilege of being afforded hour-long sessions, phone conversations between meetings, and consistent follow-up with patients is not always possible in the context of a busy medical setting where families attend visits inconsistently and see different PCPs each time, and where medical appointments are scheduled and rescheduled daily. In order to process and make sense of the families’ stories, my impact on their lives, and my own experience as a clinician, I rely on weekly reflective supervision (Parlakian, 2001) to ground and guide my clinical practice. Reflective supervision provides me with the space to sit with my feelings of sadness, frustration, pride, and ambivalence about the complex families I see. Sometimes just the act of reporting my morning, case by case, functions as a cathartic experience.

Regular supervision affords me the opportunity to think about my impact on the patients I see and deeply consider the impact they have on me. With some combination of luck and good timing, I am able to follow patients consistently and provide ongoing consultative services to the families and PCPs with whom I work. In such a nontraditional setting for a psychologist, my supervisor helps me process the impact of this work and how I truly might change families’ expectations and experiences for the better, even in one morning in clinic.

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References


