This Issue and Why it Matters

In our annual “Stories From the Field” issue of the ZERO TO THREE Journal we explore a variety of approaches to supporting young children and their families who are struggling with health, developmental, or social-emotional challenges. In this issue the authors share their experiences with the following:

- Providing trauma-informed care for a young, severely maltreated child victim of human trafficking. The authors share their experiences and the need for flexibility as needs and issues shifted over the course of 2 years.

- Integrating infant and early childhood mental health (IEMH) clinicians into primary care settings to understand the impact of a child’s environment on health and development. The authors describe three families and how their therapists considered different components of the child’s environment to guide the intervention.

- Using video-taped interactions of children and parents to promote open conversations about strengths and concerns in the relationship and the child's development. These video-based assessment and feedback sessions have been a valuable component of the work of the Wayne County Baby Court in Detroit, MI, with families involved in the child welfare system.

- Treating a toddler with a feeding disorder due to complex medical issues in a multidisciplinary system of support. The article follows the authors’ feeding intervention from when the child was 9 months to 3 years old and shows how they learned the value of following the child’s lead, team work, and family persistence.

- Teaching family members therapeutic tools to maximize the goals of early intervention. The author worked with family members to better understand and accept their child’s specific needs and challenges, and thus became better equipped to provide the sensitive, responsive, and effective guidance he needs.

In addition to these informative and insightful stories, an essay on the value of childhood immunization provides guidance on how to help parents make informed decisions and how to address concerns with sensitivity.

Letters to the Editor are welcome and encouraged. Please let us know what you think of this issue of the ZERO TO THREE Journal, and share ideas for topics you would like to see covered in future issues. I hope to hear from you soon!

Stefanie Powers, Editor
spowers@zerotothree.org

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Levels of Influence
Applying an Ecological Model in Pediatric Primary Care

Melissa Buchholz
Amy Ehmer
Yuliana Noniyeva
Rachel Stein
Bethany Ashby
Ayelet Talmi
University of Colorado
and
Children’s Hospital of Colorado
Aurora, Colorado

Abstract
Young children are influenced by the world around them and they, in turn, have an impact on their environment. Clinicians must consider all levels of influence on a young child's development when implementing interventions for young children and their families. Infant and early childhood mental health (IECMH) clinicians integrated into primary care settings are uniquely positioned to understand the impact of a child's environment(s) on health and development and support the child and family from that standpoint. This article describes three families and how their integrated IECMH clinicians considered different components of the child's environment to guide the intervention. The authors also highlight the role of reflective supervision for the IECMH clinicians.

Human beings change and develop more in the first 3 years of life than in at any other time throughout the lifespan (National Research Council & Institute of Medicine, 2000). These critical years lay the groundwork for lifelong health and well-being. Understanding the complexities of developmental processes in the early years of life can help inform approaches to support young children and their families and to ensure optimal development during the early years.

Young children develop in the context of the environments in which they exist. Bronfenbrenner's ecological model (Bronfenbrenner, 1979) described the complex systems in which children exist and develop. Environments include individual, microsystem (family structure, caregivers, siblings), exosystem (neighborhood, schools, employment, social service agencies), macrosystem (culture, politics), and the mesosystem, which describes relationships between the individual and other system levels (see Figure 1). It is important to consider how these systems interact with one another. For example, while the family environment more immediately impacts individual children (e.g., caregiver availability and involvement), the family itself is directly impacted by larger social and political systems, such as availability of employment, neighborhood safety, and racism. The broader environment may directly or indirectly impact the development of young children, as in the case of natural disasters.

Interventions targeted at any level of the biopsychosocial environment will ultimately impact the child or individual at the center. Likewise, interventions directed toward the individual child or family must be implemented in a thoughtful way, considering the levels of influence that surround the child and family. One of the surrounding spheres of influence is the health care system where young children and families seek care. As such, pediatric primary care settings are optimal places to interact with young children and their families and to identify issues families are facing in their environments. When problems arise in early childhood, parents turn to their child's primary care provider for help and solutions, frequently as the first point of contact. A family-centered medical home is uniquely
situated to assess and address individual-level issues while considering various factors that impact the child and family's environment. The medical home is a place where families with young children can turn when they have concerns as well as when things are going well. Ideally, families form close relationships with their medical home, which offers an accessible, non-stigmatizing and culturally sensitive environment (Ader et al., 2015).

**Integrated Behavioral Health Clinicians**

Primary care clinics that have behavioral health clinicians integrated into their practices are best positioned to support children as they grow and develop. More specifically, early childhood integrated behavioral health clinics can support families during those critical first several years of life (Buchholz, Fischer, Margolis, & Talmi, 2016; Talmi, Stafford, & Buchholz, 2009). Clinicians with expertise in infant and early childhood mental health (IECMH) collaborate with pediatric primary care providers to identify issues early on (e.g., attachment, pregnancy-related mood and anxiety disorders, psychosocial adversity) and devise solutions that are most likely to be successful in the contexts and environments in which a particular child exists (Buchholz & Talmi, 2012; Kaplan-Sanoff, Talmi, & Augustyn, 2012). IECMH experts also have ample opportunity to support young children and their families from a health promotion and prevention standpoint. HealthySteps is an example of one strategy for enhanced health promotion and prevention in primary care settings (Minkovitz et al., 2003). Finally, IECMH clinicians who engage in regular reflective supervision (Tomlin, Weatherston, & Pavkov, 2014) are best prepared to effectively support young children in the context of pediatric primary care.

The following vignettes illustrate the role of IECMH clinicians in the pediatric primary care setting. Each story will highlight a different component of Bronfenbrenner’s ecological model. Reflective supervision emerges as a theme throughout all of them. It is important to consider reflective supervision in the context of the ecological model with respect to how it enhances the clinician’s ability to meet the child and family's needs. All names and identifying information have been changed to protect patient confidentiality.

**Microsystem and Mesosystem: Luis’s Story**

Luis was a 21-day-old boy who attended the primary care clinic for follow-up care after spending time in the neonatal intensive care unit. At birth, it was discovered that Luis had a heart defect that required multiple surgeries. Luis comes from a two-parent family who both accompanied Luis to his primary care visit. The medical provider consulted the IECMH clinician to address Luis's mother's depressive symptoms which were revealed by a routine pregnancy-related depression screening (Lovell, Roemer, & Talmi, 2014). Luis's microsystem and mesosystem are especially important for the integrated behavioral health clinician to consider. The family was from Guatemala and monolingual Spanish-speaking. They were undocumented immigrants, which made it challenging to access health care. Due to their documentation status they were only able to work minimum-wage jobs and were, therefore, financially stressed. Finally, Luis's parents' entire social support network lived in Guatemala, and they felt alone and isolated in the
United States. Luis's parents were relieved when a Spanish-speaking clinician arrived to discuss Luis's mother's symptoms of depression. Luis's mother was tearful and explained that they were experiencing multiple stressors, particularly surrounding Luis's complex medical needs. The management of Luis's condition, coupled with the uncertainty of the prognosis was taking a toll on the family's resources. Luis's mother felt that her symptoms of depression were under control and she did not want to pursue treatment, particularly psychiatric medications, for the fear of further harming her breast-feeding infant. Further assessment revealed that the symptoms of depression, combined with multiple psychosocial needs, posed significant risk factors to an already medically fragile child and vulnerable family system.

The IECMH clinician also needed to consider Luis and his family's needs in the context of a broader mesosystem that was at play in Luis and his family's lives. The family's stressors due to having a child with medical complexity, financial stress, and social isolation were impacted by living in a country where they were undocumented and felt unsafe, not in control, and fearful. Although the clinician worked diligently with the family, medical provider, and staff to connect the family to support services, it appeared that door after door closed, as agencies in the community were not accepting uninsured, Spanish-speaking mothers with depression. The clinician began to worry about how Luis and his family would be able to overcome the multiple obstacles they faced.

A parallel process emerged: While the family was undergoing substantial psychosocial stress and helplessness, the clinicians charged with caring for Luis felt equally concerned and hopeless. Like Luis's parents who felt trapped in the unpredictability of their son's medical complications, the clinician felt trapped in a system that appeared just as unpredictable. Many questions arose as the team worked together to help this family: How can a network of support be established in the community? Can a system that is built to help underserved families continue to provide services to underserved communities amid an increasingly hostile political climate? What will happen to many other families with similar stories if the current sources of financial support stop funding programs focused on prevention? The IECMH clinician received weekly reflective supervision in which she was encouraged to reflect on her own feelings and reactions about Luis and his family. The clinician reflected on how a family in a new country may interpret unavailable services as unwillingness of the system to support them. The clinician shared her strong feelings of worry and frustration surrounding the lack of access to mental health care for a family that truly needed it. She wondered about how the family's undocumented status affected their experience in the health care system and whether their initial hesitation to seek mental health services was tied to their experience. In the safety of the supervisory relationship, it became clear that the clinician's reactions were mirroring Luis and his family's feelings of uncertainty, apprehension, and fear. The reflective process unveiled an underlying fear, anger, and sadness that drove many of the questions posed. It also revealed the importance of frequent practice exploring these feelings in a safe environment with supportive colleagues. Reflective supervision supported the clinician at a macro level—supporting her as a way of supporting the family. The clinician was encouraged to acknowledge her feelings of helplessness and yet persevere for the sake of Luis and his family.

After many failed attempts, Luis's mother was eventually connected to a site that could support her and her infant. The process of collaboration across multiple disciplines made it possible for Luis and his family to get the help they needed. The perseverance of the IECMH clinician and medical providers helped Luis and his family overcome the obstacles that existed within the microsystem, while the process of reflective supervision operated at the meso- and macrosystem levels and helped with maintaining clarity in the midst of chaos.

**Exosystem: Nathan's Story**

Nathan was brought into the pediatric medical clinic during his first week of life for his newborn well-baby visit. Nathan's medical needs were similar to most typically developing newborns that present in primary care. After a normal pregnancy, his delivery was unremarkable. Nathan's microsystem was unique, however, as his mother, Ashley, had significant cognitive delays and was herself cared for by a caretaker. Although Ashley did not have the support or involvement of his father, she was involved in Nathan's care along with his maternal aunt, and his mother's caretaker, all of whom accompanied him to this first visit.

Nathan's circumstances and his relationships with his mother, Ashley, her caretaker, and his aunt were all part of the exosystem, which provided Ashley additional support. The IECMH provider needed to fully understand and consider this level of influence on Nathan's health and development. The initial visit quickly revealed complex psychosocial issues. Specifically, Ashley expressed that she had her own cognitive impairments.
and mental health concerns, which explained the presence of her caretaker at the visit. It was clear that Ashley would benefit from additional support in the context of Nathan's primary care visits. Fortunately, the clinic implements HealthySteps, an evidence-based program designed to enhance primary care and provide additional developmental support to young children and their families in collaboration with primary care providers (Minkovitz et al., 2003). Even though all families are eligible for the program, it is often particularly useful for families who may benefit from additional information about how to care for a baby. Nathan's family agreed to participate in HealthySteps and was enrolled at his newborn visit.

Nathan and Ashley lived with the caretaker who assisted in ensuring that the daily living needs of both Ashley and Nathan were met. Nathan's aunt was also involved in caring for him, but lived in a separate household. As part of the medical visit during those first precious days of Nathan's life concerns arose about whether he was being fed properly, which even after coaching and teaching left all of the providers feeling a little bit uneasy. Keeping in mind the complexities of Nathan's environment, the team decided to bring him back to clinic a few days later for close monitoring and a weight check. At the second medical visit Nathan continued to be on track with his weight gain, suggesting that the teaching efforts were effective. While the providers were initially relieved by this progress, the IECMH clinician reflected on the broader systems and environments at play in Nathan's life and noted that they would continue to need close monitoring and support. The clinician had the opportunity to discuss this during weekly reflective supervision.

Nathan returned to clinic at 3 weeks old. Nathan was accompanied by Ashley and her caretaker at this visit. Although medically Nathan continued to make appropriate progress, the visit was quite tense. The complexities of the ecosystem were apparent as Ashley and her caretaker argued in the exam room. The tension in the room was palpable, and the IECMH clinician considered Nathan's experience as he grew and developed within this environment. Although everyone had calmed down by the end of the visit, the medical providers and IECMH clinician were left wondering what interactions between Ashley and her caretaker were like at home and the impact they had on Nathan.

Nathan's aunt brought him in for his 1-month well-child visit. Her doing so initially created confusion because it was unclear whether Nathan's aunt had medical rights. Nathan's aunt quickly informed the staff that she had emergency temporary custody. She explained that Ashley had left the home without notice after becoming upset, leaving Nathan to be cared for by her caretaker. Ashley was located a day later, after having been assaulted, but was not thought to be fit to care for Nathan after leaving him so abruptly. This dramatic change in Nathan's environment was unexpected and upsetting to the IECMH clinician and medical providers. Reflective supervision was once again critical to supporting the clinician in managing her own reactions in order to best meet Nathan's needs.

At Nathan's 2-month visit his aunt and Ashley were both present. They explained that Nathan was now living with his aunt, who had gained temporary full custody, but that Ashley was trying to be involved with his care. Throughout the visit Ashley tried to be an active participant, but was continually deterred from doing so by her sister. The strained relationship between Nathan's caregivers was apparent and was likely impacting his health and development. Eventually Ashley asked to speak with the IECMH clinician alone. She shared that she was trying to be involved in Nathan's life but was struggling because no one would listen to her opinions or feelings. She described how she was taking steps to try and get Nathan back into her life and became extremely fearful when talking about how she was not allowed to provide input on the decisions being made about his care. Clearly, several systems were at play, and the IECMH clinician and the medical providers needed to consider all levels of influence when determining how to proceed in order to support Nathan and all of his caregivers. The providers collaborated at the end of this visit and made some decisions about how visits would be managed in the future. They decided that they would make sure to include Ashley in his visits as an active participant. The team agreed that unless they received notice of a legal change that would prevent Ashley from caring for her son during visits, they would encourage her active engagement during clinic visits.

The complexity of this case required frequent conversations among care team members to reflect on the situation and consider the impact of their own reactions. Because the family situation kept changing and was, at times, volatile, the providers discussed their reactions and how they influenced their ability to provide Nathan with the most optimal care. Reflective supervision for the IECMH clinician involved working through the complexities of providing services to this family. She was able to stay focused on the ultimate goal of supporting Nathan's positive development while managing the challenges of working with a high-risk family. The clinician was able to support and involve Nathan's caregivers—even as they
continued to change—rather than becoming entangled in the family drama that was a constant backdrop at the microsystem level.

**Macro system: Jayda’s Story**

Jayda is an 8-month-old African American female who was initially seen at the primary care clinic following birth. Jayda was born at term and seemed to be developing normally. At a microsystem level, it is notable that Jayda was born to an 18-year-old mother and father, and she lived with her mother, father, maternal grandmother, two maternal uncles, and several cousins. Jayda’s parents both worked full time, and her grandmother worked in the oil industry, leading her to be away from the home for weeks at a time. One of Jayda’s uncles provided child care when her parents were both at work. The family lived about 60 miles away from their primary care clinic, but attended this clinic because of its unique nature of providing care for both young mothers (under 22 years old) and their infants and toddlers.

The primary care clinic implements HealthySteps and the family was enrolled at Jayda’s new-born well-child visit. At 3 months old, Jayda’s mother brought her to the Emergency Department on the same medical campus following an incident in which she continuously rolled her eyes back into her head and in which her arms stiffened. After a weekend at the Emergency Department, Jayda was diagnosed with infantile spasms and began the first of several treatments. At this point, Jayda’s individual factors became more significant than a typically developing infant. The parental family history was notable for epilepsy and seizure disorders. Including Jayda’s paternal uncle, who had seizures as a baby until 2 years old. This new individual factor immediately impacted her family. Jayda’s treatment plan meant increased travel to neurology follow-up appointments, twice daily steroid injections administered by her mother, and disruption to the family’s ability to continue working. This intense regimen contributed to the inherent emotional distress of understanding a potentially devastating medical diagnosis, administering treatments that carry risks of negative side effects, and witnessing changes in their baby girl.

The family’s relationship with the medical system became much more involved and the medical setting became an integral component of Jayda and her family’s environment. The IECMH clinician supported the family in the context of these relationships. She was able to attend neurology appointments to serve as a liaison by supporting the relationship between the neurologist and the family. During these appointments the IECMH clinician was able to ask for explanations to be more concrete, repeated treatment administration instructions, and explored how the family was feeling about treatment plans and decisions in an effort to increase compliance and to respect the wishes and beliefs of the family. Throughout Jayda’s treatment, her medical home providers, both medical and IECMH clinician, reached out to the family to help them coordinate additional appointments in neurology, ophthalmology, and for electroencephalograms, as well as to address resource needs interfering with medical follow-up and to inquire about Jayda and the family’s well-being.

The macro system became especially important to consider in Jayda’s case. Understandably, Jayda’s parents were incredibly distressed by her medical complications and were desperate to identify a treatment. Living in a state where marijuana is legal likely had a great contribution to Jayda’s parents’ treatment decision after the steroid injections prescribed by the neurologist failed to stop her spasms. Her parents had heard from friends that cannabidiol (CBD) oil was effective in managing their child’s seizures. This personal anecdote in combination with the unknown potential consequences and side effects of alternative treatments that were recommended by the neurologist led Jayda’s parents to forego medical treatment to pursue CBD oil. Unfortunately, Jayda continued to have several spasms a day for 2 to 3 months on the CBD oil, in addition to experiencing developmental regression and increased sleepiness. Her parents decided that they needed to pursue a different treatment option and returned to the neurologist. If Jayda happened to live in another state where marijuana is not legal, Jayda’s parents would not have been able to make this choice for their daughter.

Watching Jayda’s temperament and demeanor change drastically over a very short period of time from active and happy to fussy, then sleepy, and finally withdrawn and less responsive on CBD oil was heartbreaking for the family and all of the providers involved. Reflective supervision became especially important in helping the IECMH clinician experience all of these emotions while simultaneously supporting Jayda’s parents and advocating for what they believed was best for their baby girl. Reflective supervision created a space in which both the IECMH clinician and her supervisor could freely express personal reactions to Jayda’s diagnosis and her parents’ choices for her treatment plan. Supervision allowed the IECMH clinician to identify parallel processes including experiencing the same feelings of being overwhelmed by worry for Jayda and completely helpless like her parents.

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Although Jayda’s parents had control over her treatment plan, they felt they had no good options for her treatment and that no matter what they chose, they were harming her brain through the potential side effects. The IECMH clinician was able to provide further education to Jayda’s parents on the harm that continued spasms were having on their baby. Jayda’s parents’ feelings were validated and the clinician acknowledged that the seizures they had become accustomed to were not as scary as her parents thought of new, devastating symptoms, such as vision loss. Reflective supervision prepared the IECMH clinician to have difficult discussions with Jayda’s parents about the unseen damage that even small spasms were having on her brain. They discussed concerns that her development would likely not progress if she continued to have these seizures. Jayda’s parents felt supported in the face of indescribable stress. They decided to discontinue the CBD oil treatment and begin the next recommended medical treatment. It was essential for the IECMH clinician and Jayda’s medical home to consider the broader context in which Jayda and her family exist in order to provide them with the support they needed to make decisions about her medical care. Reflective supervision prepared the IECMH clinician to manage emotions and adequately work with Jayda and her family in the face of significant complexity.

Conclusion

Young children grow and develop in the context of relationships, environments, and systems. These levels of influence impact children and their families, particularly when adversity factors and psychosocial factors complicate the developmental context. As is demonstrated by the families described in this article, clinicians and other early interventionists must consider context and complexity when providing developmentally appropriate support and intervention. Pediatric primary care settings provide optimal environments for meeting families where they are, considering all levels of influence, and intervening appropriately. Clinics with integrated IECMH clinicians are especially prepared to meet the needs of young children. Integrated IECMH clinicians encourage collaboration among providers and increase the likelihood that young children will be understood within their multiple contexts and environments. Finally, reflective supervision operates at the mesosystem—supporting the IECMH clinicians so that they are better prepared to support families. The clinicians in the case descriptions provided all benefited from reflective supervision which allowed them to effectively intervene with these families while managing multiple complexities.

The cases described each demonstrate the importance of considering all levels of influence as outlined by Bronfenbrenner’s ecological model (1979). Understanding individual or even microsystem factors is not sufficient to meet the needs of a young child or their family. Family-centered medical homes are the optimal settings in which to understand and address issues at all levels of a child’s environment. Finally, reflective supervision provides parallel support to IECMH clinicians in evaluating all levels of the system, managing emotions and reactions to difficult psychosocial issues, and effectively meeting the needs of every family.

Melissa Buchholz, PsyD, is an assistant professor in the Department of Psychiatry at the University of Colorado School of Medicine and is a supervising psychologist in the Child Health Clinic at Children’s Hospital Colorado. She is the director of the HealthySteps program in Colorado and is responsible for the expansion and oversight of the program across the state. She also directs the HealthySteps program at the Children’s Hospital Colorado. She is faculty with the Irving Harris Program in Child Development and Infant Mental Health at the University of Colorado School of Medicine. She is interested in the integration of behavioral health into primary care settings and, more specifically, on practices that promote health and early intervention for young children in the context of pediatric primary care.

Amy Ehmer, PsyD, is a postdoctoral fellow with the Irving Harris Program in Child Development and Infant Mental Health at the University of Colorado Denver. She currently works as an infant and early childhood mental health consultant with
Project CLIMB/HealthySteps and the Young Mother’s Clinic, as well as with the Fussy Baby Network of Colorado. She is particularly passionate about working with adolescent parents and high-risk families and previously provided assessment, consultation, and attachment therapy in a teen-to-tot clinic on a predoctoral internship at Mount Sinai Adolescent Health Center in New York City.

Yuliana Noniyeva, PhD, is a postdoctoral fellow at Children’s Hospital Colorado in the Child Health Clinic. She completed her predoctoral internship at Denver Health Medical Center, where she developed her interest in training in integrated primary care. She is a multilingual practitioner with interests in preventing mental illness in pediatric populations and broadening access to care for underserved communities. She is particularly interested in advocating for systems and policy change that is focused on integrated primary care.

Rachel Stein, PhD, is a postdoctoral fellow with the University of Colorado Denver’s Irving Harris Program in Child Development and Infant Mental Health. Prior to becoming a fellow she completed a predoctoral internship with the Illinois School Psychology Internship Consortium, and her graduate work at the University of California Santa Barbara. Currently she is working with a variety of interdisciplinary teams at the University of Colorado Denver and Children’s Hospital Colorado, including as a member of the CLIMB/HealthySteps team.

Bethany Ashby, PsyD is a licensed psychologist and an assistant professor of psychiatry and obstetrics/gynecology at the University of Colorado School of Medicine. She is the director of Behavioral Health Services in the Colorado Adolescent Maternity Program and Young Mothers Clinic at Children’s Hospital Colorado, which provide medical care to pregnant and parenting adolescent girls up to 22 years old and their children. She also coordinates the PROMISE clinic at University of Colorado Hospital, a co-located clinic that provides mental health services to perinatal women. She is interested in the evaluation of mental health services provided to perinatal women, and more specifically, the treatment of trauma and comorbid mood disorders in this population.

Ayelet Talmi, PhD, is an associate professor of psychiatry and pediatrics at the University of Colorado School of Medicine. Dr. Talmi is the program director of Project CLIMB, an integrated behavioral health services program in primary care. She is the associate director of the Irving Harris Program in Child Development and Infant Mental Health. Her research and clinical interests focus on early childhood mental health in pediatric primary care settings and on systems of care for babies and young children with special health care needs. Dr. Talmi is a ZERO TO THREE graduate fellow.

References


