Building Relationships and Buffering Toxic Stress

Group-Based Medical Care With Spanish-Speaking Latino Families

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Abstract
Pregnant women and young children who experience toxic stress are at risk for negative health outcomes. The “medical home” is seen as a place to address toxic stress by promoting healthy relationships, but Spanish-speaking Latino families face challenges accessing the medical home while simultaneously confronting unique stressors. This article describes a group model for medical visits during pregnancy and early childhood, an intervention designed to promote relationships and address toxic stress for Spanish-speaking Latino families. Two examples highlight the ways that group medical care cultivates relationships at multiple levels to effectively combat adversity and increase social connectedness. The article concludes by discussing the practice and policy implications of the intervention.

Infants and young children who experience toxic stress and adversity are at risk for later health problems, including cardiovascular disease, cancer, asthma, and depression (Johnson, Riley, Granger, & Riis, 2013; Shonkoff et al., 2012). Stress and adversity are considered toxic when they are prolonged or intense—such as in family violence, caregiver depression, abuse, or the multiple challenges associated with living in poverty (Center on the Developing Child, 2007). Toxic stress can have negative and lasting impacts on brain circuitry and physiologic regulation (Shonkoff et al., 2012). Because foundational and rapid brain growth occurs during the prenatal and early childhood periods, infants and toddlers are particularly affected by toxic stress and adversity (Shonkoff, 2016). Notably, strong and supportive relationships with caregiving adults are the single most important protective factor when young children are faced with difficult life circumstances (McEwen & McEwen, 2017; Shonkoff, 2010; Shonkoff, 2016; Shonkoff et al., 2012).

Toxic Stress, Relationships, and the Medical Home
Given the relationship between early childhood adversity and later health outcomes, the medical home is increasingly being seen as a place to address toxic stress and promote positive relationships (Burke Harris, Silvério Marques, Oh, Bucci, & Cloutier, 2017; Johnson, Riis, & Noble, 2016; Shonkoff et al., 2012). However, in order to effectively reach all young children and their caregivers, the medical system must support diverse families who face unique challenges or have difficulty accessing care (Britton, 2004; Shonkoff et al., 2012). One
such group is Spanish-speaking Latino families, who often confront stressors related to acculturation, limited social support, increased likelihood of living in poverty, immigration, and language barriers (Annie E Casey Foundation, 2017; Caballero, Johnson, Buchanan, & DeCamp, 2017; Margolis et al., 2015). Moreover, Spanish-speaking families are less likely to be engaged in care in a medical home, and the rating of relationship quality with a primary care provider is lower for these families than their non-Hispanic white counterparts (DeCamp, Choi, & Davis, 2011; DeCamp et al., 2013). These findings highlight the importance of culturally competent care for Spanish-speaking families to combat the impacts of toxic stress by promoting healthy relationships during early childhood.

**Group Medical Care**

To address toxic stress and promote healthy relationships during a critical period of development, our clinic has implemented group-based medical care for Spanish-speaking pregnant women and young children. Our freestanding clinic is located approximately 15 miles away from the hub of our safety-net health system in an urban area in Colorado that faces several disadvantages compared to other city neighborhoods, including food insecurity, a significant portion of uninsured individuals, low high school graduation rates, and high rates of childhood obesity and asthma (Be Healthy Denver, 2014). More than half of our patients are best served in a language other than English, and 64% identify as Hispanic or Latino. Most Spanish-speaking patients are of Mexican origin, although families come from multiple Latin American countries. Most families are uninsured or are covered by Medicaid, and virtually all of our patients live below 200% of the federal poverty level. (As an example, an annual income of $50,200 is 200% of the federal poverty level for a household of four in 2018; U. S. Department of Health and Human Services, 2018).

The group care team consists of a medical provider, an infant and early childhood psychologist, a facilitator, and a medical assistant. The group facilitator recruits families and provides her individual contact information for appointment scheduling. The psychologist and group facilitator co-lead sessions in Spanish while the medical assistant takes patients’ vital and administers vaccines (see Table 1 for additional descriptions of group-care activities). Because the facilitator is from the community and shares a similar cultural background to group members, she delivers the curriculum’s information in a culturally consistent manner and helps build trust. The medical provider conducts the family’s individual physical within a private area that is sectioned off within the group room.

Group sessions consist of 8–12 families and last from 90–120 minutes. Women meet together 10 times during their pregnancy. After giving birth, the same cohort meets in well-child care starting at 1-month and continuing through 5 years (13

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**Table 1. Group Care Components**

<table>
<thead>
<tr>
<th>System Parameters</th>
<th>Activities</th>
<th>General Topics Covered</th>
<th>Screening</th>
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</thead>
<tbody>
<tr>
<td>Pregnancy Group Visits</td>
<td>• Time to socialize and snack with other mothers</td>
<td>Common discomforts, when to call the doctor, substances to avoid, nutrition, oral health, intimate partner violence, family relationships, birth control and family planning, breastfeeding, baby blues, pregnancy-related mood disorders, pre-eclampsia, gestational diabetes, pre-term birth, kick counts, contractions, labor and delivery, birth plans, infant care, planning for support after delivery, sharing birth experiences</td>
<td>• Pregnancy-related depression screening at intake and 24 weeks (EPDS; Cox, Holden, &amp; Sagovsky, 1987)</td>
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<td>(10 visits)</td>
<td>• Physical exam</td>
<td></td>
<td>• Intimate partner violence screening at intake and 24 weeks (HITS; Sherin, Sinacore, Li, Zitter, &amp; Shakil, 1998)</td>
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<td></td>
<td>• Weight</td>
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<td></td>
<td>• Baby shower and gift exchange</td>
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<td></td>
<td>• Stress management and relaxation (stretching, yoga, deep breathing)</td>
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<td>• Scheduling individual medical or behavioral health follow up</td>
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<tr>
<td>Well-Child Group Visits</td>
<td>• Time to socialize and snack with other mothers</td>
<td>Infant care, safety and family and sibling adjustment, breastfeeding, sleep, postpartum mood, bonding and reading cues, fussiness, infant soothing, family planning, routines, feeding, attachment, temperament, discipline, parenting goals, co-parenting, parental stress management, tantrums, limit setting, emotion regulation, peer interaction, early literacy, language development, importance of play, toilet-training, healthy eating, physical activity, screen time, community resources, early care and education</td>
<td>• Postpartum depression screening at 2, 4, and 6 months (EPDS; Cox et al., 1987)</td>
</tr>
<tr>
<td>(13 total visits at 1, 2, 4, 6, 9, 12, 15, 18, 24, 30 months; 3, 4, and 5 years)</td>
<td>• Physical</td>
<td></td>
<td>• Intimate partner violence screening tool at 2, 4, and 6 months (HITS; Sherin et al., 1998)</td>
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<td></td>
<td>• Weight</td>
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<td></td>
<td>• Infant massage</td>
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<td>• Tummy time</td>
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<td>• Music class</td>
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<td>• Library and reading</td>
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<td></td>
<td>• Play time</td>
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<td></td>
<td>• Birthday party celebration</td>
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<td></td>
<td>• Scheduling individual medical or behavioral health follow up</td>
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Note: EPDS = Edinburgh Postnatal Depression Scale.
visits. Below, we describe two cases that show the value of culturally adapted, group-based medical care for infants and young children and their Spanish-speaking caregivers. The cases are designed to highlight the way that group care offers an opportunity to address toxic stress and promote Spanish-speaking families’ relationships with their young children, with each other, and with the medical home. We conclude by discussing practice and policy implications. All personal information in vignettes has been changed to maintain confidentiality.

Guadalupe and Kimberly

Guadalupe, a 31-year-old monolingual Spanish-speaking woman, first entered our health care system at 8 weeks gestation to confirm a positive pregnancy test. Originally from Mexico, this was Guadalupe’s first pregnancy with her current partner, with whom she had been living for 5 months. Guadalupe also had two children (14 and 12 years old) living in Mexico with their grandmother. Aside from her partner, her only support was a cousin living in the same metro area. Guadalupe’s initial Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden & Sagovsky, 1987) score was a 15, indicating mood symptoms but no suicidal ideation. Her intimate partner violence screener was negative. She declined to speak with a psychologist at her first visit, indicating that her stress was related to the unplanned nature of her pregnancy.

At her first prenatal care visit, Guadalupe received routine individual medical care and met with the group facilitator to discuss participation in group. Although she remained reserved during the discussion, Guadalupe agreed to join. Starting at 13 weeks, Guadalupe attended groups monthly but rarely spoke during the sessions. The pregnancy curriculum directly addresses toxic stress such as perinatal mood disorders and intimate partner violence. During the group conversation on intimate partner violence, in addition to identifying the different types of intimate partner violence and discussing resources for women, two women disclosed their previous experiences in abusive relationships in Mexico. Guadalupe listened attentively, although the facilitators noted that she was quiet and not actively participating.

At her 30th week of pregnancy, Guadalupe missed her group appointment for the first time. When the facilitator reached out to reschedule and problem-solve any barriers to attending care, Guadalupe began to cry. Declining to elaborate further on the phone, she agreed to come in the same day for an individual appointment. Guadalupe revealed to her medical provider that her partner had been violent with her for the first time, hitting her head against the wall during an argument. She then met with the psychologist with whom she was familiar from group. She did not want to report the violence to police fearing repercussions given her immigration status. She also disclosed a past history of intimate partner violence with a previous partner that resulted in her leaving her two older daughters with her mother in Mexico and fleeing to the United States. The two discussed her history of loss and trauma, completed a safety assessment, and reviewed community resources and supports. As her pregnancy progressed, Guadalupe continued to attend group visits. While the team monitored her safety and checked in regularly, she remained ambivalent about leaving her partner. However, she began participating more actively in the group, and she eventually disclosed her situation to a few of the other women who had overcome similar circumstances.

Guadalupe stayed with her partner throughout the pregnancy and delivered her daughter, Kimberly, full-term at 39 weeks. After leaving the hospital, Guadalupe was running low on food and felt unsure how to obtain diapers. She reached out to the group facilitator, who connected her to a clinic social worker able to assist in securing concrete material resources, including the Women, Infants, and Children (WIC) nutrition program and community agencies that provide infant supplies. Furthermore, two women from the group in whom she had confided brought her infant supplies and drove her to her medical visits when she lacked transportation.

Guadalupe returned with Kimberly to the clinic at 1 month postpartum for her next group visit. She had a positive EPDS screen with a score of 11 and met individually with the psychologist. Kimberly’s bottle was propped on a blanket in her car seat, and Guadalupe endorsed feeling sad and overwhelmed. She expressed a desire to separate from Kimberly’s father and a readiness to access resources that would help her do so. She and the psychologist made an initial safety plan for her to leave the home and live with her cousin. Together they called a local hotline, and Guadalupe talked with a worker about the services that she would receive, including safety planning assistance, legal protections for her and Kimberly, counseling, and a case manager to help navigate the path forward.

Kimberly’s 2-month visit was quite different. Guadalupe seemed excited to be meeting with the other women, and her mood had brightened. She was breastfeeding Kimberly,

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A photo taken after an infant well-baby group.
whom she held in her arms and fed during group. At several points during the visit, Kimberly let out a shrill cry. Guadalupe comforted her, moving around the room as the group talked about infant soothing, increased alertness over the second month, and cultural views about colic. The other women smiled at Guadalupe and talked with her frequently, noting how well Kimberly was growing. An individual check-in with Guadalupe’s medical provider revealed that her anxiety was greatly reduced and she had been able to connect to the intimate partner violence agency, where she had set up long-term counseling, received legal support, and had case management assistance. She reported that the other mothers had been vital in supporting her and Kimberly—Guadalupe often texted them to ask their opinions on infant care questions or met them for coffee in the community.

At Kimberly’s 4- and 6-month groups, Guadalupe was similarly responsive and attentive to her daughter and was happily engaged chatting with the other mothers. The pair participated actively in the 30-minute music lesson designed to promote language skills and social—emotional development. Guadalupe wondered about returning to work, and several of the other mothers offered to watch Kimberly if she needed child care.

At Kimberly’s 6-month group, Guadalupe had obtained work and had child care help from her cousin and another mother in the group. Kimberly was showing healthy signs of attachment to Guadalupe, who became increasingly confident as a mother and responded to Kimberly’s distress while smiling and encouraging Kimberly during play. Although there would certainly be challenges ahead, through group care, Guadalupe had formed strong relationships with her daughter, other mothers in her community, and her health care team. These bonds would continue to be critical resources for the family moving forward.

Lilian and Damian

Damian lived with his mother, Lilian, his father, Juan, and a 7-year-old sibling named Alberto. Lilian had participated in pregnancy and well-child care, although Damian had missed several group visits during his first year of life, which required the facilitator to reschedule him for individual visits. The group facilitator reached Damian’s mother before his 18-month well-child visit and was able to confirm his attendance in the group meeting. Damian arrived 30-minutes late, when the guest speaker from the library had just started to read aloud with the other families in group. While observing the families and their interactions, the psychologist noted that Damian evidenced odd stereotyped behaviors, including repetitive play with the objects in the room, limited vocalizations and words, and an unusual focus on his own activities. The psychologist alerted the medical provider to her concerns and emphasized the importance of reviewing his Ages & Stages Questionnaire (Squires & Bricker, 2009) and Damian’s autism screeners, which his mother had completed with assistance. Due to Lilian’s low literacy, a medical assistant helped administer the screen verbally to ensure that Lilian was able to accurately provide her perspective.

Lilian’s report on the screeners suggested that Damian’s development was on track with the exception of communication. With querying, she identified no elevations on his autism screener. Although the screeners were not entirely consistent with the psychologist’s observation during the group visit, the medical provider focused on the common concern about Damian’s speech delays. The medical provider discussed a referral to early intervention, but the mother declined, saying that she preferred to contact a teacher that provided in-home support with her older son. The medical provider knew that oftentimes, families are fearful due to immigration-related concerns and are wary about providing their personal information. She recruited the psychologist and the facilitator to talk further with Lilian about early intervention and elicit additional concerns. Even after the discussion, Lilian continued to explain that she preferred to reach out to the teacher and refused to permit the referral to be sent.

Together, the medical provider, the psychologist, and the facilitator reflected on Lilian’s hesitance. The facilitator remembered receiving a call from Damian’s mother about immigration concerns when she was pregnant with Damian, and the facilitator wondered whether, despite the team’s reassurances, Lilian remained fearful about the consequences of providing her information. The psychologist reached out to Lilian in a month to follow up, and Lilian agreed to schedule another appointment with her medical provider. At Damian’s developmental follow up with her medical provider, the medical provider discussed common concerns about early intervention, including fears about having others in the home or that the agency would provide the family’s information. Lilian highlighted that she continued to be concerned about Damian’s speech, particularly after reflecting on how the other children Damian’s age behaved in group. At this visit, Lilian accepted a referral for early intervention.

Two months later, the facilitator received a call from Lilian, who was distressed and explained that early intervention raised concerns for autism, which was consistent with the medical
team’s initial impressions. Lilian was confused about what this meant and needed help understanding the meaning of autism and her next steps. The facilitator connected Damian to the psychologist, who set up an individual appointment with Lilian. Together, they looked through his early intervention report, discussed the meaning of autism, and reviewed cultural and family beliefs about the diagnosis. They also jointly called Lilian’s early intervention service coordinator to determine next steps in obtaining a diagnostic evaluation. During the visit, the psychologist reflected on the positive social–emotional behaviors that she observed Damian performing, including single words to request objects and the use of his mother as a secure base. Lilian looked proud upon hearing these observations. She noted that after learning about his delays through early intervention, she began to realize the importance of responding to his cues and engaging him in joint activities. In the future months, Damian continued to receive early intervention and was placed on a waiting list for a diagnostic evaluation. Although he required ongoing support, his mother had become his advocate, planning for the future and the type of classroom he would need, identifying the importance of exposure to other children to support his social development, and reaching out to the clinic for support around her and her family’s concerns. At subsequent group meetings, she helped reduce stigma by talking with the other mothers about connecting to early intervention and explained the progress she had seen Damian make.

**Critical Components of Group Care**

Guadalupe, Kimberly, Lilian, and Damian highlight the ways in which group-based medical care that is adapted for Spanish-speaking women and their infants combats toxic stress and promotes healthy relationships. In Guadalupe and Kimberly’s case, the family faced multiple adversity factors, including social isolation, parental history of trauma, pregnancy-related mood symptoms, intimate partner violence, immigration-related stress, and material resource needs. For Lilian and Damian, social isolation, low literacy levels, immigration concerns, and developmental needs were sources of stress. In the face of these challenges, relationships were formed at multiple levels. By engaging in care with the same cohort over time, Lilian and Guadalupe reduced their isolation and created strong networks with other women in their community. They connected with mothers from a similar cultural background, which led to both emotional and instrumental support. The group format promoted Lilian’s and Guadalupe’s relationships with their children by reducing parental stress and offering bonding opportunities such as music, reading, and play. In addition, the curriculum increased maternal knowledge of child development, helping the mothers understand and respond sensitively to their children’s needs. Provider continuity and extended time with the two families created strong relationships with the medical team and increased parents’ confidence and comfort accessing the health care system. The structure and multidisciplinary staffing of the group provided multiple ports of entry for the two families, which allowed Lilian and Guadalupe to address the stressors facing their families and receive appropriate support. These ports of entry included pregnancy-related mood screening six times throughout the perinatal and post-partum period, regular

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**Learn More**

- *The Centering Pregnancy Model: The Power of Group Health Care*  
  S. S. Rising & C. H. Quimby (Eds.) (2016)  
  New York, NY: Springer

- *The Deepest Well: Healing the Long-term Effects of Childhood Adversity*  
  N. Burke Harris (2018)  
  New York, NY: Pan Macmillan

- Ted Talk: How Childhood Trauma Affects Health Across a Lifetime  
  Nadine Burke Harris (2015)  
  [https://www.youtube.com/watch?v=95ovIJ3dsNk](https://www.youtube.com/watch?v=95ovIJ3dsNk)

- Center for the Developing Child  
  [https://developingchild.harvard.edu](https://developingchild.harvard.edu)

- The Resilience Project  

- Protecting Children From Toxic Stress,  

- Toxic Stress Toolkit  

- Healthy Steps  
  [https://www.healthysteps.org](https://www.healthysteps.org)

- Frameworks Institute  
developmental screening with support for families with low literacy, extended observations by psychologists in everyday situations, assessment of parent–child relational quality over time, the identification of common stressors among women, and the sharing of culturally meaningful coping mechanisms. The bilingual and bilingual facilitator created an atmosphere of trust, group cohesion, and family engagement, which allowed Lilian and Guadalupe to have a clear point of contact to access the medical home. The emphasis on provider continuity ensured that resources and recommendations were not simply given to Guadalupe and Lilian, but were delivered as part of an ongoing process of understanding the families’ goals and needs. Extended time with a psychologist supplemented developmental and mood screening with clinical observations and allowed for a thorough assessment of the parent–child relationship while destigmatizing mental health support.

Through this team approach, families’ mood, mental health, stress levels, and resource needs were addressed while conducting routine pregnancy and well-child care, allowing for a two-generation approach to improving young children’s outcomes. The cases also make clear that to truly combat toxic stress, healthy relationships must be built to extend outside the medical home—the social networks that the women created with each other and their linkages to outside community agencies were critical in buffering the impact of toxic stress on their young children.

Policy Implications

Research shows that there are financial and health benefits to investing in early childhood, including the prevention of poor life outcomes and chronic diseases in adulthood (Heckman, 2012; Shonkoff, 2010). In many cases, however, these benefits may not be fully realized for decades (Burke Harris et al., 2017; Heckman, 2012). Although the group model of care helps to engage Spanish-speaking families, addresses toxic stress, and promotes relationships, this model is not fully sustainable and has depended on grant funding to support behavioral health clinicians on the team. In order to provide comprehensive care for diverse populations, enhanced reimbursement should be offered for practices that implement evidence-based approaches to decreasing the impact of adversity on the development of young children and their families. Ultimately, disseminating family-centered, culturally informed, and creative solutions should be a priority to ensure a healthy start for all families, regardless of their cultural and linguistic backgrounds.

Catherine Wolcott, PhD, is a bilingual clinical psychologist and assistant professor at the University of Colorado Anschutz Medical Campus. She completed a post-doctoral fellowship in infancy and early childhood through the Harris Program in Infant Mental Health. Her work in early childhood has focused on integrated behavioral health services for pregnant women and infants, access to culturally sensitive health care for Latino families and young children, and addressing exposure to toxic stress and trauma in demographically at-risk populations.

Lara Penny, MD, MPH, is the clinic director at Montbello Family Health Center and is bilingual in English and Spanish. She is a family physician with 20 years of experience in a community health center setting, and her career has been focused on serving families living in poverty. Lara has been at Denver Health Medical Center for 11 years, and she has been instrumental in expanding the group-based model of care to young children and families within the Montbello system.

Lisa Wanger, MS, PA-C, has 15 years of experience in family medicine and is bilingual in English and Spanish. Lisa has been providing medical care in a group setting for 10 years, and her passion is maternal–child health and serving families living in poverty. She has been an employee at Denver Health for 5 years, where she has worked to increase the number of families served in a group medical setting and has advocated for integrated behavioral health to help reduce the impacts of toxic stress.

Ayelet Talmi, PhD, is an associate professor of psychiatry and pediatrics at the University of Colorado School of Medicine and director of integrated behavioral health in the Pediatric Mental Health Institute at Children’s Hospital Colorado. Dr. Talmi is the director of Project CLIMB, an integrated behavioral health services program in pediatric primary care. She is the co-director of the Irving Harris Program in Child Development and Infant Mental Health and the co-lead of the First 1,000 Days Initiative at Children’s Hospital Colorado. 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 Leaders for the 21st Century Graduate Fellow and a past president of the Colorado Association for Infant Mental Health.

References


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