Chapter 12
Stories from the Exam Room: Case Examples of Healthy Steps Interventions at Montefiore

Laura Krug and Polina Umylny

Abstract Healthy Steps at Montefiore follows the integrated care model in which clinically trained behavioral health professionals, with expertise in early childhood development, trauma, and attachment theory, are embedded within general pediatrics practices to meet with families in a universally accessed, non-stigmatized setting. Healthy Steps Specialists intervene at three levels to address the multiple concerns that families bring to their child's pediatrician. First, Healthy Steps Specialists implement a universal screening program, working alongside pediatricians to identify families of infants with historical or current psychosocial stressors, and provide services intended to prevent the transmission of trauma across generations. Healthy Steps Specialists also work with families of children, aged birth to 5, who require short-term interventions related to concerns about behavior and development, including difficulties with feeding, sleep, tantrums, and aggression. Finally, Healthy Steps Specialists provide mental health interventions to parents of very young children in order to address concerns that may impede a parent's ability to attend to their children's developmental needs. Four vignettes included in this chapter offer examples of these levels of intervention.

Keywords Healthy Steps • Integrated behavioral health • Early childhood • ACEs • Maternal trauma

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Healthy Steps Specialists intervene at three levels to address the multiple concerns that families bring to their child's pediatrician:

L. Krug, L.C.S.W. (✉) • P. Umylny, Ph.D. (✉)
Montefiore Health System, Bronx, NY, USA
e-mail: lkrug@montefiore.org; pumylny@montefiore.org

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1. Healthy Steps Intensive Services: Healthy Steps Specialists, working alongside pediatricians, implement a universal screening program, to identify families of infants with historical or current psychosocial stressors, and provide services intended to prevent the transmission of trauma across generations. Families can also be identified prenatally when mothers attend their obstetric appointments.
2. Healthy Steps Consultations: Healthy Steps Specialists work with families of children, aged birth to 5, who require short-term interventions (approximately one to five sessions) related to concerns about behavior and development. Children can be referred for a variety of reasons including difficulties with feeding, sleep, tantrums, and aggression.
3. Parental Mental Health: Healthy Steps Specialists provide mental health interventions to parents of very young children in order to address concerns that may impede a parent's ability to attend to their children's developmental needs. Parental Mental Health Providers provide evidence-based individual therapy to the parent, while always keeping the parent–child dyad in mind.

The four vignettes included in this chapter are examples of these levels of intervention. All names have been changed to protect confidentiality.

Intensive Services

Intensive Services works particularly well when babies are referred very early, sometimes even prenatally, and Healthy Steps Specialists are able to meet families at the newborn visit or soon after, when parents are overwhelmed, exhausted, and deeply humbled by the birth of their baby. The following vignette is based on a family enrolled in Healthy Steps Intensive Services at a Montefiore pediatric clinic in the Bronx, NY.

After completing the well-baby checkup on 1-month-old Genie, Dr. Johnson came to find the Healthy Steps Specialist.[1] Genie was the youngest of four girls being raised by Luisa, a single mother. Dr. Johnson had been caring for Genie's three older sisters for several years, and knew that Luisa and her children had spent the last 9 years moving between homeless shelters in three of New York City's five boroughs. In addition, Genie had been born early and underweight, had spent several weeks in the NICU, and Luisa was clearly anxious about her infant's well-being. Dr. Johnson appropriately thought the family could benefit from the support of the Intensive Services program and made the referral.

After the "warm handoff" with Dr. Johnson, Luisa agreed to meet with me in the exam room. As many parents do, Luisa had a great deal of trust in her children's pediatrician, and was willing to accept her endorsement of me as a respected

[1] Adapted from "Integrating Behavioral Health Support Into a Pediatric Setting: What Happens in the Exam Room?," K. Cuno, L. M. Krug, and P. Umylny, 2015, *Zero to Three, 35*(6) p. 11–16. Copyright 2015 by ZERO TO THREE. Adapted with permission.

colleague. The primary goals at this first meeting are to establish rapport with the parent and to provide concrete examples of how enrollment in Intensive Services would be helpful for the family. It is also an opportunity to observe the parent–child relationship at a very early point in its development.

I explained that I was a Healthy Steps Specialist, available to answer additional questions, review typical newborn milestones, and introduce Luisa to fundamental concepts regarding brain development. I also mentioned that I hoped to ask Luisa questions about her childhood experiences. Luisa was open to meeting with me and I began by asking how she was doing and if she had any questions or concerns about caring for Genie. From our first meeting it was evident how anxious Luisa was about Genie's health. We discussed these worries so that Luisa would know that this was an appropriate context in which to address such concerns, and I worked to ensure that Luisa felt heard. I provided information on strategies for feeding and soothing Genie and Luisa was able to practice these techniques in the exam room during our session. There was no time to explore Luisa's history during this first meeting, but fortunately integration into pediatrics almost always ensures that families will return soon, due to the well-child visit schedule.

Luisa and Genie returned to the clinic the following week for a weight check, and Luisa was thrilled to report that Genie seemed to be eating more and had put on some weight. I encouraged her to notice how Genie's behavior had changed since birth. She noted, with some regret, that Genie frequently seemed angry, only smiling in her sleep or when looking up at the light. I noticed mother's negative attribution as potentially indicative of relationships from her past, and we discussed how a baby's smile was reflexive at this age and that over the next few weeks it would develop into a social smile. Luisa appeared relieved and I inquired if she had been warned by friends or family to be careful not to spoil Genie. Luisa agreed and stated, "I even tell the girls to put the baby down, but they don't always listen." Luisa also confessed, "I can't help it, she's just so small. I know I should let her cry it out but I can't stand it." This was the perfect opportunity to debunk the prevalent myth that soothing young babies creates excessive dependence, and support Luisa's innate need to respond to her baby's cues to nurture Genie.

I discussed the "serve and return" nature of brain development, how Genie learned from the responses she consistently received from her caregivers, and that when Luisa soothed Genie over and over again, Genie would gradually learn to sooth herself. My goal during these discussions was to support the development of a secure attachment between parents and babies by encouraging Luisa to imagine how the security Genie felt from Luisa as a baby would serve Genie well as she grew older. Providing an accessible explanation of brain science and explaining that brain development in infancy was the foundation for all later learning is a crucial component of early Healthy Steps visits. I encouraged Luisa to reflect on Genie's current capabilities and acknowledge how completely dependent she was, and that Luisa was not creating a dependency, but appropriately meeting Genie's needs. Finally, I explained the difference between nurturing a young baby versus "indulging" a toddler and explained how a consistently nurtured baby develops into a more independent child.

Luisa seemed eager to hear this. “It’s okay to hold the baby?” she asked to confirm. “Absolutely! Not only is it okay to hold the baby, it’s great to hold the baby.” Luisa’s relief was palpable. “We can work together, when you come in to see Dr. Johnson, to see how things are going, and to discuss how you care for Genie. Over time, I will encourage you to gradually allow Genie to tolerate some frustration. But for now, nurture her as much as you can.” I stressed that she would decide exactly how to raise her baby and her children. I explained that I would offer information, and support her and her family, regardless of her decisions.

At this visit, I also had the opportunity to complete the Adverse Childhood Experiences (ACEs) questionnaire (Felitti et al., 1998). When Healthy Steps Specialists first began screening parents with the ACEs, we were apprehensive about asking personal and often painful information about their pasts. While not all parents reveal a history of childhood trauma, many do. I introduced the screening to Luisa by noting that many parents at our clinic had a “rough go” as kids, and that research tells us trauma tends to repeat generation after generation. I explained that our goal was to support parents who experienced trauma as kids, in an effort to prevent repetition in this generation, our patients. “It’s true,” Luisa said. “There is a lot of that in my family.” I began by asking Luisa who raised her and she reported being cared for by multiple family members until she moved out on her own at age 16. She endorsed both physical and emotional abuse and noted that her single mother was largely absent and addicted to drugs. Luisa described her story in a minimalist and matter of fact manner, as if she did not want to give the memory too much credence. She explained that she preferred not think about her past, and she was clearly more focused on her children’s well-being than her own. She denied any history of her own drug abuse, mental illness, or domestic violence.

The ACEs screening is not a comprehensive psychosocial history, but we believe that it is useful to identify parents at high risk for challenges with attachment and repetition of abuse. In addition to identifying those babies most at risk, screening can bring the painful and often deeply hidden memories into the present, where they can be openly addressed. I have never met a parent who thought their baby was at risk for abuse, and the parents who can speak about their abuse histories with their Healthy Steps Specialist may be the most resilient in preventing its repetition. The families who refuse to answer the questions, or fail to acknowledge the trauma they experienced, may be the most vulnerable. However, there is always another opportunity to connect them with Healthy Steps at their next visit to the pediatrician when their doctor may observe a small comment or gesture suggesting the vulnerabilities that lie beneath the surface.

I met with Genie and Luisa a few weeks later at the 2-month checkup. Luisa happily reported that Genie was continuing to gain weight and was smiling socially, cooing, and kicking enthusiastically when Luisa or the other girls played with her. Despite these developmental milestones, Genie’s health was an ongoing struggle during her first year of life, with several hospitalizations and frequent trips to the emergency room. When Genie came for her many pediatric appointments, Luisa and I met to see how she and the girls were managing. In the absence of a family

crisis, Luisa spoke almost exclusively about Genie. Though Luisa was devoted to her three older daughters, I doubted that they were able to see this devotion past Luisa's sleep deprivation and irritability.

In my work with parents, I spend much of my time encouraging them to interpret and respond to their infant's language, much like I did in the first few sessions with Luisa. As the months went on, however, I veered in a slightly different direction, encouraging Luisa to identify times when she could, quite literally, look up from her singular focus on Genie, so that she could better address the needs of her older children. She was not convinced when, at the 6-month visit, I suggested that giving Genie a chance to problem solve, soothe, or entertain herself was important for her development, but she agreed to implement the strategies I recommended and "see what happens."

While Luisa doted on Genie, she expected her older daughters to embrace her own approach to life: live up to your responsibilities and count your blessings. This philosophy left little room for limit testing or even playfulness. It was only a matter of time before Luisa's anxiety over Genie's health would shift to frustration over her burgeoning independence. Consequently, we spoke a great deal about limit setting in very young children. At the 9-month well-child visit, when Luisa began to describe Genie as "demanding…just like her older sister," referring to 4-year-old Leah, I acknowledged that caring for the needs of very young children can be depleting, and we spoke about how her children's strong mindedness can also serve them well in life. I pointed out that I saw the same streak of independence and perseverance in Luisa, and how those attributes had helped her overcome many of life's obstacles. At this same visit we learned that the family had been moved to a shelter in Brooklyn, though Luisa was continuing to take the subway and several busses to get the older girls to their schools in the Bronx, and continued to bring her family to our clinic for their medical care. Between pediatric and Healthy Steps visits, Dr. Johnson and I wrote letters and made phone calls to the Department of Homeless Services, requesting that the family get a medical transfer to a shelter closer to the clinic, so that Genie could continue to receive medical care at her established medical home.

By the 12-month visit, the family had been moved back to the Bronx, but the toll of life between boroughs had worn away at the family's ability to cope. When we met after Genie's physical, Luisa told me that 14-year-old Carlie was cutting school and "having sex with boys" in stairwells of buildings. In the midst of the family's daily struggles, Carlie had been given more responsibility for caring for her younger siblings than she was ready for, and she directed her anger at Luisa. Luisa shared how much she feared for Carlie's future. With her own history of abuse and trauma, Luisa had struggled to create a different life for her daughters. Carlie's behavior was, for Luisa, evidence that she had failed, and that all four of her children were destined to repeat her own life course. I worked with Luisa to remind her of the ways in which she had already made her daughters' lives different from her own childhood experiences. She had avoided abusive relationships, limited her children's exposure to violence and drug use, and kept their days as routine and consistent as possible, within the limitations of life in the shelter. I encouraged Luisa to accept a referral for therapy, both for Carlie and herself, but she insisted that she would be able to manage the difficulties on her own.

When I walked in to the exam room to meet with the family 6 months later, at Genie's 18-month-old well-child visit, I found Genie sitting on the exam table, with Luisa standing by protectively. Carlie and Leah were attempting to read Genie a story, while Genie seemed intent on claiming the book as her own. I also learned that the family had some good news to share. Carlie bubbled over with enthusiasm to tell me that the family had finally moved out of the shelter and into their own apartment. As we celebrated the family's new home, Luisa followed this news with another accomplishment. "Carlie is on the honor roll!" Luisa told me, with more relief than pride. This news, and Luisa's enthusiasm in sharing it with me, seemed like a good barometer of how well the family was doing.

During this visit, I also noted that Luisa had started to describe Genie as "smart and independent," and had begun to allow Genie to do more on her own. She also spoke more kindly and less harshly to her older children. I pointed out that Luisa was doing an admirable job letting the girls work out the conflict over the book, and that her daughters were showing strong negotiation skills. When I revisited concerns about limit setting, Leah chimed in, "She keeps hitting me!" I agreed that 18-month-olds can be impatient and easily frustrated, and pointed out that Genie may not yet have the words to express herself fully and so may lash out instead. We spoke about the power of attention, both parental and sibling, to shape behavior, and to teach Genie to start to identify and express her feelings. I also stressed the importance of immediate and logical consequences, and the older girls "practiced" how they would respond to Genie the next time she hit.

The visit ended as positively for the family as it began, and I stressed that Luisa and her children had all worked hard to get to this point, with so many successes to share. We reviewed upcoming milestones, and Luisa and I agreed to meet at Genie's next checkup.

While Genie's family presented well in the snapshot of this visit, I knew that they had many hurdles ahead. Working in an integrated pediatric setting, Healthy Steps Specialists have the luxury of knowing that we will see families on a regular basis, as attendance at pediatric appointments is a priority for most parents. In addition, because families remain enrolled in our program until the child's fifth birthday, Healthy Steps Specialists are able to work with families over an extended period, allowing opportunities for families to make significant changes during a child's most vulnerable phase of development.

This aspect of the program became critical 1 month after Genie's 18-month visit. Luisa had discovered that Carlie had continued to have sex with multiple partners, and brought her in to the clinic for pregnancy and STD tests. While Carlie met with her pediatrician, Luisa, Genie, and I met in my office. Importantly, at this visit, both Luisa and Carlie agreed to a referral for therapy. Because of our integrated model, I was able to introduce Luisa and Carlie to the clinic's pediatric social worker, who was able to schedule an appointment for the following week. When Luisa brought Carlie in for that appointment, she also agreed to meet with Dr. Bassett, our Parental Mental Health Psychologist. While Luisa was always eager to implement any strategies that I suggested,

overwhelmed by her traumatic history and chaotic circumstances, she often struggled to understand things from her children's perspective. I hoped that becoming involved in her own treatment would enable her to be more empathic towards her children.

Behavior and Development Consultation

Healthy Steps consultations integrated in general pediatrics benefit both families and pediatricians. Parents frequently seek help from pediatricians, asking advice on a myriad of behavioral and developmental issues. Pediatricians, in turn, often feel as if they have neither the time nor the expertise to address these concerns effectively. Providing behavioral health and developmental specialists allows for a more holistic approach to pediatric care, allowing providers to identify and treat children's difficulties early, before those difficulties become both exacerbated and entrenched.

Ms. Castillo brought her 3-year-old son, Michael, to see the pediatrician when his daycare center threatened to kick him out due to poor behavior and aggression. She and her husband were raising Michael and her three boys (ages 4, 7, and 12 years old) from a previous relationship. Dr. Edwards referred the family to Healthy Steps, and due to time constraints, after a brief introduction, we scheduled a consultation for the following week. I noticed that the family had been referred the year before, with the same concerns, but the parents never followed through with their first appointment. I imagined that Michael's behaviors at 2, without the benefit of intervention, had become very challenging.

Michael entered my office with a bright and friendly smile. He immediately began to play with toys, talking happily and showing his parents his discoveries. Mr. and Mrs. Castillo redirected Michael from time to time to return toys before taking out new ones. Michael was compliant with their requests and demonstrated no defiance during our discussion. Michael's parents reported that their home was very busy with four boys, but that Michael was the only one who gave them much trouble. They reported that they had a daily routine including homework time, bath time, dinner, and free play. I was impressed with the significant structure they had created. They noted that they both worked full time and that Michael's maternal grandmother watched the older boys until Mrs. Castillo came home in the evening, picking up Michael from daycare on her way.

The Castillos reported that Michael was always "hyper," ignored their directions, and had explosive tantrums when he did not get his way. Michael's behavior at school was similar, and included bullying and aggression toward the other children. They added that Michael resisted their attempts to create routines, and that bedtime, in particular, had become a series of battles. Michael also often woke up in the middle of the night to play or raid the refrigerator. They voiced concern that Michael was a danger to himself when he was up at night unsupervised. Recently, they woke up one morning to find he had hidden a take-out container under his pillow and had

a face covered in bar-b-que sauce. Mr. Castillo noted that he had been diagnosed with ADHD as a child and feared that Michael had it as well. I immediately felt empathy for this dad, who was raising three well-behaved stepchildren, and struggling with his own.

I began my response by establishing ground rules, explaining that Healthy Steps behavior and development consultations at our clinic were limited to a few visits, and that patients who required more interventions were referred out. I ruled out that Michael had been exposed to any trauma in his short life, such as domestic violence, parental mental illness, substance abuse, child abuse or neglect. Screening all consultations for trauma is an important step as posttraumatic stress reactions are frequently misdiagnosed as hyperactivity and defiance. I explained that Michael was too young to be diagnosed with ADHD, and normalized some of Michael's high activity as typical of children his age. I applauded the Castillos for coming to the appointment, as early intervention is critical. I noted that if Michael's behaviors persisted and interfered with his ability to learn once he was in school, they could request a psychoeducational evaluation through the school district.

I explained that multiple factors affect children's behavior, including temperament, developmental stage, their caregiving environment, past experiences, and consequences (both positive and negative) for behavior. I commended the Castillos on their efforts to maintain a calm and structured home, with four young sons, and noted that it appeared that Michael required a different kind of parenting than his siblings.

Next, I worked to get a sense of what strategies the Castillos were already using to manage Michael's behavior, and I clarified how the Castillos attempted to establish limits. Both parents agreed that they did not give any consistent consequence when Michael ignored their efforts to enforce routines and limits. The Castillos did not hit their children, but were at a loss about what to do instead. The Castillos had both been raised with corporal punishment, had made a conscious decision to parent differently, and were frustrated that Michael's behavior seemed to discredit their theory that respectful parenting would be rewarded with well-behaved children.

I noted that while in my office, and without the challenge of competing for attention, Michael seemed to have little difficulty with compliance, and played in a calm and well-organized manner. Mr. Castillo noted that he could not remember the last time when being with Michael was so calm and peaceful. They agreed that during this discussion, Michael had been getting a great deal of support and attention from his parents, and acknowledged that, with two jobs and four children, sitting in a room just with Michael and allowing him to play was its own novelty.

This discussion allowed for an introduction of the importance of parental attention in shaping children's behaviors. We discussed the importance of giving Michael lots of positive attention when he behaved well, and to remove their attention when he misbehaved. The Castillos spoke about how ineffective they felt as parents, and I stressed that Michael, like most children, would continue to show them the behaviors that they pay the most attention to, and that by using a combination of planned ignoring and positive attention, they could start to shift Michael's behaviors.

As an example, we worked to identify two problem behaviors, spoke about what the "positive opposite" of those behaviors might be, and discussed how to use

language (in particular, specific praise and narrating Michael's positive behaviors) to reinforce the behaviors that the Castillos were looking for. Armed with these strategies and a few carefully selected handouts, I asked the Castillos to practice these skills in the office, while playing with Michael and following his lead. The Castillos were good sports, and were quickly speaking over each other in an effort to identify Michael's positive behaviors. Although initially reluctant to commit to similar activities at home, explaining that they had so little time to get everything done in a day as it was, both parents agreed that at least one of them would be able to play with Michael in this way every day in order to practice the skills we had discussed today. I stressed that spending a few minutes playing with Michael, and following his lead, would be important. These 5-min "special play time sessions" add up quickly and ensure that parents have time set aside to foster a strong relationship with their child.

We then discussed how they could apply some of the strategies we had discussed today to avoid and manage Michael's tantrums. I stressed how "giving in" to Michael's tantrums, because it was difficult for both of his parents to tolerate his distress, was actually encouraging more tantrums. I suggested that when Michael had tantrums, they explain to him that he would finish his tantrum in his room and come out when done.

Although it had been a full session and we were running short on time, I felt obliged to address their concerns regarding Michael's nighttime adventures, and suggested that attaching a bell or other noise creating object to his bedroom door would wake one of them up and remove the secrecy of his behavior. The Castillos, although actively engaged in the visit, voiced feeling skeptical that any changes they made would have an impact on Michael's out of control behavior. We agreed to meet next week to check their progress and revisit these concerns.

At the next session, the Castillos reported that they had diligently practiced their skills during playtime with Michael. Michael was eager to tell me that he enjoyed the special time with his parents, and his parents agreed that his behavior was very different during these play sessions. They also reported successfully directing Michael to his room during tantrums. Ms. Castillo voiced amazement after noticing how much calmer she felt when the tantrums were not occurring at her feet. While this change gave them hope for more change to come, they were concerned that shifting their attention alone would not address all of Michael's behavioral difficulties. I agreed and explained that in this session we would focus on setting limits and rules, giving effective commands, and following through on consequences, both when Michael complied and when he ignored or defied their limits.

We identified specific rules that the Castillos wanted Michael to follow and they both agreed that his aggressive behavior was their greatest concern. "Keeping hands and feet safe" became a family rule that Michael and his parents could all agree on. I suggested that they immediately put Michael into a time out, well away from any family activity, after aggression. We discussed giving Michael clear and consistent warnings for non-aggressive misbehavior, by giving him three chances, or "strikes," and that if they said the words "strike three" he received a time out. We also discussed setting up a chart of the series of activities around bedtime, so that Michael could check off each step as he completed it.

Throughout this session, I gave very explicit recommendations to the Castillos, checking in with them to make sure that the recommended strategies seemed fair and kind. I encouraged them to continue to track Michael's progress, and to focus on the changes that Michael was making in his behavior, rather than on what they still wanted to change.

At Michael's third visit, he immediately began to play with the toys and the Castillos reported that they were seeing some results. While Michael continued to be extremely demanding and had a hard time sharing, he was staying in his room during tantrums and standing in the hallway for time outs. Mr. Castillo voiced amazement that Michael complied with their directions during time outs.

During our conversation about Michael's improvements, I noticed that he was quietly tossing blocks from the bin over his right shoulder, onto the floor. Mrs. Castillo quickly told him to stop, which he ignored. I reminded mom to clearly define her limits by giving him a first strike warning and encouraged them to discuss where the time out spot would be in my office. Michael ignored the strikes and cried while standing in corner for his time out. I restarted the timer after he kicked a toy and he remained quiet in the corner for the duration of his 3 min. We commended Michael for calming himself down and his father reminded him why he received the time out in the first place, finishing the statement with the question "Are you ready to play nicely with the toys?" Michael nodded and perfectly illustrated his capacity for self-control.

As Michael returned proudly to his activity, we discussed his progress up to this point. Mrs. Castillo confessed that she had not embraced the recommendations as quickly as her husband. She noted that she had a harder time controlling her frustration and tended to send Michael to his room without the three strikes or clearly defined time outs. Mr. Castillo proudly observed that the more control he felt, the more effective his discipline was; "We are talking more and yelling less." Ms. Castillo agreed that Michael was responding so well to the structure and limits, that it was as if he wanted them. I agreed and noted that although young children desire control and independence, they thrive in the security of a safe and structured environment. We discussed ways in which Mrs. Castillo could recognize when she was growing irritable with Michael and use it as a cue to begin giving three strikes.

Mrs. Castillo also brought up a common issue for parents: how to address their children's behavior, especially tantrums, in public places. Michael had a tantrum on the bus the previous week when his mother forgot to let him insert the Metrocard. He began screaming and crying until Ms. Castillo, mortified, got off the bus at the next stop, and walked the rest of the way home instead. I commended mother on her instincts and discussed how the natural consequence of walking home may have impacted Michael. We also reviewed additional strategies for helping Michael understand expectations during trips on the bus or errands to the grocery store in advance, and how to reinforce and support his behaviors during these outings.

I invited the Castillos to reflect on their initial concerns that Michael had ADHD and fears that he would be a "behavior problem" for a long time. They appeared to be as proud as Michael had been, leaving his time out and returning to the toys. We discussed how crucial it was to remain calm and self-regulated when trying to teach a child how to calm down and self-regulate. Of course, we laughed, how can you

teach a child to calm down when you are yelling all the time? Mr. and Mrs. Castillo never had to put a bell on Michael's door, to alert them when he was up at night, as his nighttime adventures had stopped. I encouraged them to reach out to school to discuss Michael's improvements and to make sure the strategies used in both locations were consistent. We scheduled another follow-up appointment in a month to check in on Michael's progress, and to use as a booster session, if needed.

In many ways, the interventions which helped Michael dramatically change his behavior were quite basic and similar to what any clinician might use as part of a parent training protocol. The innovative component of this vignette is that it occurred in the pediatric clinic with a 3-year-old patient. Left untreated, it is very likely that Michael would have been kicked out of his daycare program, and perhaps diagnosed with Attention Deficit Hyperactivity Disorder or Oppositional Defiant Disorder by the time he reached elementary school. Michael's positive outcome is a testament to his parent's ability to easily access resources, their openness to changing their own behavior, and the importance of early identification and treatment.

Consult for Trauma

While most Healthy Steps consultations are related to concerns about children's challenging behaviors or developmental delays, having a clinically trained psychologist or social worker on site at a pediatric clinic can be useful for many difficulties faced by the families of very young children. Below is a vignette of a family seen at a clinic in the South Bronx, one of the poorest congressional districts in the nation, with the associated psychosocial stressors that often accompany living with poverty, including exposure to violence.

Dr. Kallowitz stopped by my office after seeing 2-week-old Sam and his mother. Dr. Kallowitz had known the family for 4 years, since the birth of Bella, Sam's older sister. While she had few concerns about the family in general, Dr. Kallowitz wanted to refer the family to Healthy Steps because of something that Erica, Sam and Bella's mother, had revealed at the visit. Dr. Kallowitz had casually asked about how Andre, the children's father, was doing, and Erica shared that he was recovering from a gunshot wound, and was only recently able to return to work.

Erica and Andre had been together for 7 years, and moved in together, with Andre's mother, Jessica, when Erica became pregnant with Bella. Erica was willing to speak with me and share the details of what had happened with Andre on the night that she delivered Sam. She explained that she had been taken to the hospital following a scheduled visit with her obstetrician. She was not due for another week, but was not surprised to learn that she was having contractions. She called Andre to let him know to meet her at the hospital. Andre left work and called his mother to share the exciting news. Andre explained that he was on his way home to pick up Erica's already packed hospital bag. Jessica, in turn, was eager to let Bella know that her baby brother was on his way. In their enthusiasm, Bella and Jessica waited by the window and watched for Andre to come running into the

building. As Andre was running in, however, an argument erupted between a group of men near the building, and both Bella and Jessica heard the gunshot and Andre's cry of pain as the bullet hit his shoulder. The other men scattered, and Andre went up the stairs to see his family. Andre was ultimately taken to a different hospital from Erica, but was released and was able to make it to the delivery room before his son was born.

Despite the challenges prior to Sam's birth, Erica described an easy delivery and explained that she was glad to be back home with her family. She shared that Andre's wound was not serious. She was, however, concerned about Bella, who had clearly witnessed something terrifying. She explained that Bella seemed to want to share her memories of the shooting, asked many questions over and over again, and refused to go back to preschool. However, she was not having nightmares, had not developed any new fears, and had not demonstrated any regressive behavior. Erica explained that they tried to distract Bella from her focus on the shooting, hoping she would forget about it as soon as possible.

When I met with Erica and Bella later that week, Bella walked into my office with a smile on her face, eager to play with the toys provided, and to share her disappointment that Sam was not quite the playmate she had expected. She also told me that her father had "a boo boo" on his shoulder, but that it was getting better.

I enrolled the family in Intensive Services, and in addition, met with them several times over the next 2 months to address the concerns about Bella. Andre was not able to attend sessions because of his work schedule, though Erica regularly brought his questions to our appointments.

During these sessions we spoke about the importance of continuing to allow Bella the space to ask questions and speak of her experiences about the shooting, and the language to use in answering her questions in a developmentally appropriate manner, including the use of "feeling words." I also stressed the importance of communicating to Bella that, even though something scary happened, it was her family's job to keep her safe. I explained that maintaining routines and schedules was important in helping Bella both adjust to the birth of her baby brother and to reestablish a sense of security following the traumatic event. With this in mind, we were able to develop a plan to help Bella return to preschool.

I encouraged the family to pay attention to any changes in behavior, and explained that difficulties could arise at later points in development. Over the next year, Erica checked in with me when she brought the children for their medical appointments. Bella continued to do well, and, when I last saw the family before they moved out of the neighborhood, she was a highly articulate and playful kindergartner.

We include this example because it conveys a critical point in our work with families: while we cannot directly change the community in which they live, supporting parents to provide a warm, nurturing, and safe space in which children can grow impacts how children respond to the challenges and stressors of their everyday and potentially toxic environment. Erica and Andre's response to Bella's worries determined how she was able to interpret it, and supported the development of coping skills and self-regulation. Indeed, stressful events only become "toxic" for young children when they are unmitigated by caregivers.

Parental Mental Health

The following is a description of Parental Mental Health services, a therapeutic intervention based on the idea that supporting the mental health of the parent is critical for the well-being of the child. Integrating therapy services into primary care significantly reduces the multiple barriers that prevent many patients from accepting mental health treatment. New parents visit pediatric practices more frequently than they do any other medical facility, making it an ideal, yet often overlooked, venue in which to deliver services.

Leilani and her parents enrolled in Healthy Steps following her 2-month well-baby checkup with the pediatrician. At that early time in our program, the only enrollment criteria (due to a research protocol) were to be a first-time parent and to speak English. Leilani's mother, Susan, denied any history of childhood trauma. Susan and Abdul, in their early 20s, were eager to nurture their newborn, attended every appointment together, and discussed their experiences of being first-time parents. Susan and Leilani lived with her parents and brothers, and although Susan's parents did not approve of Abdul, he visited frequently.

At each visit, I provided anticipatory guidance and screened the parents for depression and anxiety. While neither parent reported symptoms or history of mental illness, we recognize that the birth of a child is a stressful life event, and strive to constantly assess parental well-being. As Leilani grew, I addressed the concerns of many first-time parents, including sleep training, managing tantrums, and picky eating. Abdul stopped attending pediatric appointments after Leilani's 18-month-visit, and Susan reported that although she and Abdul were no longer romantically involved, Leilani continued to see her father and his family on the weekends.

During Leilani's 30-month checkup, Susan reported being diagnosed with panic attacks following a few visits to the emergency room in the last month. She had already met with a psychiatrist, but expressed reluctance about using medication or talking about her personal life with a stranger. When I suggested that I could start seeing her to address these concerns, she was willing, as she reported that she felt she knew me well already. At her first therapy session, Susan explained, with pressured speech and tangential thoughts, that she did not believe her diagnosis of Panic Disorder was accurate, and that she was convinced that she had an undiagnosed cardiac problem. She was so confident that she was going to have a heart attack, she feared traveling to work by subway, and therefore missed shifts frequently. This in turn led to the very realistic fear that she could lose her job. Susan explained that she could not predict what triggered these episodes of chest pain, shortness of breath, racing heart, and sweating, and, therefore, never knew when the next one would strike. She was terrified that if she died, her daughter would be left alone.

I began by reviewing the symptoms of panic attacks and providing psycho-education on Panic Disorder. Although she could not imagine why she would be having panic attacks when she had no reason to be anxious, she acknowledged that her symptoms met the diagnostic criteria. She was relieved to learn she could meet with a psychiatrist on site at our clinic. In addition, attending sessions with the psychiatrist and myself on the same day made scheduling work shifts and child care arrangements easier.

Despite her initial ambivalence about her diagnosis, Susan embraced therapy and was open to talking about her feelings and experiences during our sessions. She also began to talk about our sessions with her family at home and soon learned that multiple family members, including her mother and aunt, also struggled with anxiety. Susan took pride in knowing that, unlike her family members, she addressed her symptoms directly and openly, something she hoped to teach her daughter to do as well. When we talked about the importance of recognizing warning signs of panic attacks and practicing relaxation techniques, she shared that with her family as well. As her confidence in therapy grew, Susan reported that she also noticed that she was more patient with Leilani, and more responsive to her needs, as she was less preoccupied with her fear of panic attacks.

Importantly, Susan also began to describe the dysfunctional relationship she had with Abdul. She voiced anger at his inconsistent and unreliable visits with Leilani, despite his not working or having any conflicting commitments, and her resentment that he did not contribute financially to her care. She casually mentioned that he screamed obscenities at her and sent her denigrating text messages in response to her requests to schedule the visits Leilani always asked for. I was struck by the fact that, even though I had been working with Susan for almost 3 years, this was the first time that she mentioned this abusive behavior to me. Susan was surprised when I suggested that these threats could be triggers of her panic attacks. In fact, she denied that Abdul's threats scared her, and was convinced that he would never actually hurt her. As we explored this further, however she slowly acknowledged how disturbed she was by Abdul's treatment of her and how his behavior (both his inconsistent caregiving for Leilani and his explosive temper) was affecting Leilani. While Susan noted defensively that she tried hard not to argue in front of Leilani, she acknowledged that their fights over the phone and texts were so upsetting that Leilani was clearly aware of the situation. Susan began to connect her symptoms of anxiety to earlier arguments with Abdul. By this point, she had shared so much of her treatment with her family members, that they began to coach her to hang up the phone when they noticed her getting upset on a call, or reminded her to breathe, a strategy we had first practiced in session, when she became agitated and began to pace following one of these conversations.

Susan continued in therapy for 10 months. She arranged for family members to watch Leilani for many of the sessions, so that she would be free to speak openly, and loudly, to express herself fully. She was gratified as her panic attacks grew less frequent and she gained confidence in both recognizing her symptoms of anxiety and using relaxation techniques to keep the most severe symptoms at bay. We established rules for safe communication with Abdul, and plans for how she could respond when his anger began to escalate. Medication helped initially, and she worked with the psychiatrist to gradually wean herself off, as she began to feel more capable of coping with her anxiety. She recognized that her new ability to regulate her affect helped her see choices in her behavior and gave her much more control over her life. The more control she felt over her life, the less she felt like a victim of Abdul's moods. As she reflected on her progress, Susan voiced confidence that Leilani was learning an important lesson too; she would never keep her daughter

from her father, but she would not tolerate being mistreated by him or anyone. Susan's pride in mastering her symptoms was as strong as her initial panic regarding her mortality, and she began to date for the first time, and earned recognition for excellent work on the job.

Over the course of her treatment, not only did Susan conquer her debilitating symptoms, she also gained great insight about herself and her relationship with Abdul, lessons that both she and her daughter would most certainly benefit from. Seeking care in the pediatric clinic allowed her to begin treatment from a trusted provider quickly and conveniently and reduced the risk of her symptoms continuing untreated, an outcome that would have had significant personal and economic impact on her entire family.

Integrating mental health professionals, with a background in early childhood development, attachment theory, and the deleterious impact of trauma and toxic stress in primary pediatric practices is an efficient and cost-effective strategy for providing evidence-based care to the greatest number of families. Patients and their families can seek care in a convenient and non-stigmatizing environment and pediatricians are freed from addressing presenting problems beyond their expertise. Healthy Steps Specialists are able to identify vulnerable families and at risk children, and intervene early, supporting parents' abilities to build trusting and responsive relationships with their infants and young children. Providing therapy and psychiatric services for parents within the pediatric setting further increases the chances that families will get the intensive mental health services they need. Healthy Steps Specialists have the unique opportunity to work to prevent the transmission of multigenerational trauma and promote secure attachments, which buffer those most susceptible to the impact of toxic stress.

Reference

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