# Reflective Consultation in Child Care for Medically Fragile Young Children

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**Abstract**
Consultation in infant mental health is a relationship-based approach to building reflective capacity in professionals who work with young children. Consultants support various professionals such as child care and medical providers with meeting the social, emotional, and developmental needs of infants and children. This article describes a reflective approach to consultation (Johnston & Brinamen, 2006) in a child care setting for children with complex medical needs. The authors provide examples of consultation at various levels (child, classroom, and director).

Infant mental health is multifaceted; it is challenging and emotionally taxing in addition to being rewarding and uplifting. This combination of emotions calls for reflective practice, including reflective supervision, to ensure effectiveness, reduce burnout, and improve impact. Reflective practice is an established way of interacting with others that has been a hallmark of infant mental health for decades. Reflective practice involves a constellation of techniques that prioritize the importance of relationships to facilitate self-understanding and a consideration of how complex interactions and events occur. A goal of reflective practice is to improve the impact and effectiveness of professionals' work by supporting them to engage in continuous learning and insight into their own experiences and consideration of how those experiences impact their work.

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Reflective consultation is a type of reflective practice that emerged as an approach to prevention and intervention services for young children, wherein clinicians with expertise in infant mental health engage with alternative settings (e.g., child care centers, primary care clinics, early intervention, and child welfare teams) to provide support to other professionals who interface with young children (Ash, Mackrain, & Johnston, 2013). Reflective consultation is a critical strategy for providing a continuum of services to young children and their families. A primary goal of consultation is to build the reflective capacity of the adults in the system as they do their work to support the young children in their care. Infant and early childhood consultants promote self-reflection and growth not by what they do

or say but in how they are in relationship. Consultation in infant and early childhood settings requires a way of being in relationship to create a holding environment that allows the consultee to keep the young child in mind. There is extensive literature detailing the intricacies of mental health consultation (Johnston & Brinamen, 2012; Jones Harden, 2005; Weigand, 2007) and outlining the complexities of the work. An early childhood consultant must consider multiple factors including adult mental health, adult relationships, child mental health, relationships with caregivers, and systems influences. Consultation presents the opportunity to transform a system, and consultation from a reflective standpoint can enhance the likelihood and nature of the transformation.

## The Consultative Stance Framework

Johnston and Brinamen (2006) described a framework for consultation; a strategy from which consultants can and should operate to embody reflective practice. The "consultative stance" highlighted in their book outlined 10 fundamental components of consultation that successful consultants rely on to impact the systems in which they are embedded (see Box 1). Although Johnston and Brinamen described the stance in reference to consultation in child care settings, the same principles can be applied in settings such as primary care offices or other medical clinics, child welfare, early intervention (Ash et al., 2013). In all settings, the consultant encourages reflection and growth in the consultees and builds their reflective capacity so that they are best able to care for young children.

The consultative stance is useful in multiple settings where consultation is likely to occur. The practice of consultation in child care settings recognizes child care providers as having a critical role in the physical, social, and emotional development of a young child but understands that child care professionals are often undervalued. Children typically spend long hours with these professionals, and the quality of their relationships has consequences on a child's functioning. Consultants in this setting use reflective techniques and avoid holding the expert position, instead supporting staff and directors to reach their own conclusions regarding difficult situations. The consultant must consider all dynamics that may be at play such as challenging adult relationships, conflict between staff, challenging relationships with families in the setting, and even community influences such as violence or poverty.

Consultation in medical settings is similar to consultation in child care settings in many ways, but there are also some distinct differences (Buchholz et al., 2017; Talmi, Stafford, & Buchholz, 2009). Medical settings are often fast-paced and demand quick solutions in cases of medical complexity. It can be challenging for medical providers and other staff to hold the young child in mind, consider all perspectives, and recognize the importance of relationships as the context for any successful intervention. Therefore, it is imperative for the consultant

### Box 1. Elements of the Consultative Stance

The following is a brief description of each element of the consultative stance, adapted from the original text (Johnston & Brinamen, 2006).

1. **Mutuality of endeavor**
   The consultant collaborates with the consultees to develop a mutual understanding of the child and situation that takes into account the consultees' background and expertise. Together the consultant and consultees develop a plan for next steps.
2. **Avoiding the position of the expert**
   The consultant must support the consultees in developing confidence in their own expertise and experience in any given situation. While the consultant brings knowledge and expertise, she must avoid offering quick solutions and prescriptive advice that may undermine the development of collaborative solutions.
3. **Wondering instead of knowing**
   A consultant supports consultees with a deeper understanding of their experiences and the children and families they are working with when he wonders with them, rather than providing answers. Wondering helps to slow down the process and helps consultees consider the complexity of a situation resulting in more thoughtful and effective responses.
4. **Understanding another's subjective experience**
   A consultant must take into consideration that consultees bring their own experiences, perceptions, and expertise into all interactions. This background is important to comprehensively supporting consultees to understand and shape their reactions to children and families.
5. **Considering all levels of influence**
   The consultant must remember that the consultees do not work in a vacuum. There are multiple factors that influence the way consultees think about and respond to children in their care. Understanding these factors helps the consultant have a comprehensive understanding of the consultees' experiences and respond appropriately.
6. **"Hearing and representing all voices" (Pawl, 2000, p. 5)**
   The consultant brings others' perspectives (including the child's) into conversations with consultees. Doing so encourages the consultee to also consider others' perspectives and broadens their capacity to respond differently or more effectively.
7. **The centrality of relationships**
   Early childhood mental health and development occur in the context of relationships. Therefore, the consultant must promote the development of supportive, open, and healthy relationships as the foundation for effective consultation.
8. **Parallel process as an organizing principle**
   The consultant recognizes that people will treat others the way they are treated. When a consultant respects and values the consultees' views and feelings, she builds the consultees' capacity to respect and value the children in their care.
9. **Patience**
   The consultation process requires a slow and intentional process in order to ensure progress. The consultant must not rush the process, remembering that children currently in the consultees' care may not benefit to the extent that future children will benefit.
10. **Holding hope**
    The consultant recognizes that the consultees' work may be exhausting and thankless. The consultant holds hope for growth and progress even when the consultees are unable to do so.

Source: Adapted from Johnston & Brinamen, 2006

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Reflective practice is an established way of interacting with others that has been a hallmark of infant mental health for decades.

in these settings to slow down, be patient, and consider all voices—particularly those of the young child.

## The Medical Day Treatment Center

"The Center" (name has been changed to protect confidentiality) is a medical day treatment for infants and toddlers with complex health care needs that is located in an urban environment. The Center is a combination of a medical setting and a child care center, which creates a unique opportunity to provide infant mental health consultation. Children who are patients of The Center range in age from 6 weeks to 4 years old. To qualify to be a patient at The Center, a child must have the need for at least two therapies (e.g., physical, occupational, speech therapy) as well as a medical need that requires nursing care (e.g., a tracheostomy, a gastrotomy tube). The goal of The Center is to provide an environment where young children with special health care needs can interact with peers and develop socially, emotionally, and physically in a context where their medical needs are fully addressed by skilled nursing staff.

The staff of The Center consists of nurses, therapists (occupational, physical, and speech), medical and therapy assistants, an early childhood special educator, and teaching assistants. The staff provides medical care to infants and toddlers enrolled in the program 5 days per week and creates a learning environment that is tailored to individual children's needs. A typical day at The Center consists of many activities that are a part of typical child care settings such as playing with play dough, reading stories, teaching children to take turns, holding infants when they are fussy, and putting children down for a nap. However, these days are interspersed with medical interventions such as gastrostomy-tube feedings, suctioning a tracheostomy, physical therapy interventions, and dressing changes. The environment is intense, and staff must quickly vacillate from their roles as nurses and medical assistants to child care providers and teaching assistants. Staff members form very close relationships with the children and their families, and these relationships create critical contexts in which children are able to grow and develop in this setting.

For the past 8 years The Center has had a mental health consultant available to their team. The consultant is a post-doctoral fellow who is receiving training in infant and early childhood mental health and receives reflective supervision throughout a 1-year tenure at The Center. The consultant is present at The Center for 2 half-days per week and spends time in the classrooms with children and providers, interacts with parents during drop-off, and leads "mental health meetings" 2 days per month. These meetings create a space for staff to reflect on a particular topic (e.g., managing fussiness, behavioral interventions), discuss a challenging situation in the classroom or with a family, or process staff experiences in their various roles. The consultant at The Center intervenes at three levels—the child and family level, the program staff and classroom level, and the director and system level. The following case examples will illustrate these three areas of consultation in this unique setting. (Identifying information has been changed to protect client confidentiality.)

## Child and Family Intervention

Molly was a 2-year old little girl who had endured several complicated and traumatic medical interventions starting at birth that required lengthy hospitalizations. Molly's enrollment at The Center was her first exposure to a child care setting outside of her home and therefore required thoughtfulness about how to support her and her family with the transition. Upon Molly's arrival, the mental health consultant spent time checking in with her family and supporting The Center staff. Molly's medical needs were complex; she required a gastrostomy tube and needed multiple treatments throughout the day. Both Molly's parents and staff members seemed stressed by the hand-off of her medical care to The Center, as there were many logistics that needed to become routine during the early part of Molly's time at The Center.

In the midst of all these medical factors, however, there was a toddler. Molly was nonverbal and could not express her needs directly with language, yet she could express so much with gestures, actions, and facial expressions. At times she appeared bored, and at other times, she seemed anxious or in pain. There were familiar sounds in the space—sounds of her own and other children's medical equipment—and yet some of the sounds were new—crying, laughing, singing, quiet music. The consultant wondered out-loud with the staff: What did Molly think of this new place? How did she feel when her parents left each day, and when they returned? The consultant offered the following reflection to the staff: What did Molly need, and how would she communicate her needs to staff?

The consultant's reflective stance of wondering about Molly resulted in an early goal of helping staff to wonder, too. The consultant observed Molly's behaviors and reactions in the classroom and later asked staff for their interpretations of her functioning. Molly's parents gradually became more

comfortable leaving her at The Center, and staff became more accustomed to her medical care regimens. With this adjustment, staff appeared more able to notice Molly's affect and bids for connection, and they formed meaningful relationships with her. Staff members greeted her upon arrival each morning, talked to her while they cared for her, and encouraged her to begin forming relationships with her peers. Soon the staff began to notice that specific behaviors (fussiness and hitting herself in the head) were connected to a particular medical treatment she needed several times throughout the day. They sought the consultant's input in the hopes of alleviating some of her stress and their own as they found the treatment unfamiliar and Molly's response to treatment distressing.

What was Molly trying to tell us? The consultant shared her observations with the staff in an effort to reflect on the accuracy of her impressions and to have an opportunity to inquire into what this treatment was like for them as well. Several theories began to emerge, and the consultant learned more about the specific treatment and the experiences of other children who engage in a similar regimen. The information gathered through observation and research was shared with the staff and with Molly's parents. Together, the adults involved in Molly's care began to consider the information in the context of Molly's experience and wondered together how best to support her.

The consultant reached out to other medical professionals engaged in Molly's care outside of The Center. The consultant wondered with the classroom teacher about the possibility of adding specific types of supports to the classroom space in order to further support Molly during her treatments while also considering the flow of instruction and interaction in the room. Again, the consultant shared information with staff members and wondered about ways to implement new ideas. Each time this reflective wondering took place, staff members took the ball and ran with it. Staff created new equipment, shifted objects and furniture in the room, observed their own interactions with Molly, and made a concerted effort to notice and to be with Molly.

Even with the efforts of the staff, Molly continued to experience distress during this treatment. However, because of the supports staff members had put into place, much of Molly's day was now comfortable. Staff members continued to grow in their understanding of Molly's inner world, due perhaps in part to their own growing comfort, which may have allowed for more opportunity to notice Molly and to spend time with her instead of focusing solely on the medical aspects of the procedure. As a result of these efforts, she had integrated into the relationships in the classroom, interacted with friends despite many limitations, and engaged in the classroom schedule with regularity. She smiled and communicated using very limited sign language and was very much a part of The Center community. The reflective stance of wondering with the staff created an opportunity to discover more than just a solution to Molly's distress. It afforded opportunity to consider what Molly was experiencing and to use the wondering of that experience to form deeper relationships between Molly, her family, and staff at The Center.

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## Program and Classroom Intervention

While spending time in the classrooms, the consultant noticed that new children who started at The Center easily became "lost" in the shuffle of activity and established group norms. Depending on the medical needs of the child, his initial interactions with staff could be enduring a procedure or observing another child receiving medical interventions. Further, the busy morning schedule resulted in staff moving in and out of the room. The demands of the setting and population, staff unfamiliarity with the new child's cues, and the child's variable ability to communicate often colored the initial days of the child's experience in this new setting.

Noticing a potential area of consultation, the consultant discussed her observations with the staff to understand their subjective experiences and learn whether they also viewed a child's first day and adjustment to The Center as areas to address. The consultant met individually with the classroom teachers to discuss logistical considerations and the competing demands associated with these transitions. The consultant used a wondering stance to encourage reflection on children's experiences and how staff could use this time to develop relationships with children new to the setting. After these discussions, the staff identified the goal of supporting adjustment and caregiver–child attachment from the moment children started at the Center. Together, staff decided that a child's first day in the setting would consist of the classroom teacher spending as much one-on-one time as possible with the child and taking additional time talking with parents to learn about the child and establish a relationship with the family. The lead nurse and teacher would work together to revise the staffing schedule to ensure coverage across duties.

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In this instance, the consultant was able to highlight the importance of caregiver–child attachment and adjustment to the setting by supporting staff with a process that designated a child's first morning in the classroom as time for the teacher to establish connection with the parents and to support a child's transition into the new setting. By closely accompanying the child through the first day activities, the child had an adult to whom he could reference or seek out as he navigated the new setting. Reminding staff to consider transitions and adjustment from the beginning helped encourage staff to put processes in place to reassure children, in turn placing relationships at the center of children's first experience at The Center.

## Director and System Intervention

The consultant in this setting has opportunities to use reflective consultation to help leadership take new approaches to promote organizational, staff, family, and child well-being, as was the case with Alexander. Alexander was a 2-year-old Asian-American boy who had multiple behavioral challenges, in part due to a syndrome that impacted his motor movements, feeding, and sleep. As a result of his condition, he evidenced hyperactivity, aggression, and difficulty controlling his impulses. His family lived in an environment with multiple social stressors, but they were dedicated to supporting him and working with The Center staff. Alexander's strengths included his sociability and playfulness, his capacity to form strong relationships with staff, and supportive and dedicated caregivers at home. Although Alexander's behavior had always been challenging, staff members and the consultant began noticing increases in his aggression. He began pushing other children, biting, spitting on staff and other children, and forcefully bumping into objects.

The consultant learned that the director was considering discharging Alexander from The Center, information that came as a surprise. From the consultant's perspective, The Center was able to accommodate tremendously complex medical and developmental needs and also had the capacity to manage significant behavioral challenges. The consultant knew that she would need to approach the director mindfully and in a regulated manner in order to address her questions about the decision to have Alexander stay or leave. The consultant used reflective supervision to explore her feelings about the idea of Alexander being asked to leave and came up with a plan to talk with the director using a reflective stance.

A few days later, the consultant approached the director during an informal check-in and explained that she had heard that Alexander might be asked to leave The Center. The director emphasized her concerns, noting that the safety of Alexander and the other children was being threatened as a result of his behavior. The consultant validated the director's challenge in maintaining the staff's and children's safety while also creating an environment to help Alexander thrive and grow. After processing the director's concerns, the consultant wondered aloud with the director how The Center might respond if a child's safety were being put at risk by an increasingly complex medical problem related to a medical condition. The question encouraged the director to see the situation from a different perspective, and she noted that, in the case of a medical condition, there would likely be staffing changes to accommodate the new issue in addition to enhanced family coordination. The consultant thought together with the director about the implications of having Alexander leave The Center. Together, they considered how staff members might view behavior problems moving forward, how classroom level issues (e.g., need for more intensive structure and routines) might become attributed to individual children in the future, and the ways Alexander's relationships with the staff could be trialed to generate positive outcomes.

The consultant and director collaborated to identify a plan to help implement increased support. The director agreed that Alexander could benefit from one-on-one support during transitions throughout the day. The consultant and the director together identified one staff member that Alexander had formed a strong relationship with and agreed that this person should be the one to provide one-on-one support. The consultant agreed to review the previously developed behavior plan with the staff member who would be providing one-on-one support. The consultant and the director also discussed how the director would talk with the staff to help ensure everyone was on board. The director and consultant emphasized the parallels between medical and social–emotional issues and the need for structure, communication, use of relationships, and a team approach to ensure Alexander's success.

With the plan in place, Alexander's behavior began to improve. The consultant helped the staff problem solve difficult issues and further explored the strong emotions that staff felt when managing Alexander's behavior. The consultant continued to report this information back to the director, who was happy to see that Alexander's unsafe behavior had been significantly reduced. Gradually, one-on-one support was lessened, and

Alexander successfully graduated from the program. Through reflective consultation, the director was able to gain a new perspective to help her team manage behavior problems at The Center.

## Reflections and Next Steps

As these stories show, consultants capitalize on multiple ports of entry, even the small ones, to build the reflective capacity of the providers in this setting to support children in their care. Each year, the consultant accomplishes a tremendous amount in this setting. More importantly, the body of work that has cumulatively been accomplished year after year is significant. However, there are also several challenges that arise with having a new consultant rotate through the setting each year. The staff have to "warm up" to each new consultant, and it takes the consultant several weeks to gain his or her bearings in the setting and conceptualize the role. Ultimately, however, the consultant is able to participate in the parallel process of transition and growth, helping The Center support the new children entering their care by developing strong relationships and forming new perspectives. Through reflective infant mental health consultation, we have seen significant impacts on the children, families, staff, and director to enhance the care of young children with complex medical needs.

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