Beyond the First Exposure: The Physical, Mental, and Emotional Toll of Violence
Webinar Held: June 27, 2012
Participant Questions with Presenter Responses

QUESTIONS	RESPONSE	ADDITIONAL INFORMATION
Q: There seems to be a hesitancy for PCP's, pediatricians to refer to mental health professionals for parenting/adult emotional issues. How can this be addressed in the medical community?	PCPs may fear being viewed as nosy, intrusive, bossy or patronizing. This is why it is so important that PCPs develop a non-threatening, non-judgmental, and culturally competent way of discussing these critical risks to the child's development. Educating healthcare professionals on the ecobiodevelopmental framework and toxic stress is a start, but then those professionals need to know how to effectively communicate and partner with families to optimize the child's development. Once there is a dialogue going, actually addressing these concerns will likely require a community effort and collaboration (e.g., engaging Early Intervention services; referring to a new mother's support group; and, for extreme cases, referring to children's protective services).	
Q: What are the best treatment options for a parent/mother displaying emotional neglect for the child?	There are several evidence-based interventions, but access to them is often an issue. Parent-Child Interaction Therapy and the Nurturing Parenting Program are two examples.	
Q: What are the risks of prescribing medication for childhood depression without talk therapy for children ages 6 - 12 years old?	From an ecobiodevelopmental perspective, depression is a developmental outcome resulting from a complex, dynamic dance between environmental/experiential factors and genetic predispositions. Medications provide an opportunity to alter brain chemistry, the biological response to certain environmental cues, and, overtime, brain connectivity. Counseling, on the other hand, is an opportunity to build the adaptive, healthy coping skills required for future health and wellness. Ultimately, there is an important and even synergistic role for both medications and counseling.	
Q: Are you all willing to share your PPT slides with those of us doing trauma and ACEs awareness building in our communities, with proper citation of course? GREAT presentation materials!!	Sure. I'll leave it up to the AAP as to how they can best be distributed/downloaded.	All presentation materials are available at http://www2.aap.org/sections/childabuseneglect/MedHomeCEV.cfm#Education
Q: Is your group utilizing and promoting use of the 5 Principles of Trauma Informed Care?	I personally prefer the following description of TIC (from Hopper, Bassuk, and Olivet, "Shelter from the Storm: Trauma-Informed Care in Homelessness Services Settings," *The Open Health Services and Policy Journal* , 2010, 3, 80-100): “Trauma-Informed Care is a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.” Our goal for this first webinar was to build an understanding of the impact of trauma.	
Q: Have your members started to incorporate ACE screening questionnaires into their practices and will this be the recommendation from your task force moving forward?	An official "ACE score" is based on the number of different CATEGORIES of self-reported adversity experienced prior to the age of 18. Hence, it actually minimizes the trauma by NOT accounting for multiple episodes of adversity (where you abused once or repeatedly?), nor for multiple kinds of adversity within each category (if your mom was an alcoholic and your dad used marijuana, that would still be just one point for household substance abuse). While some communities are embracing ACE scores as a way to promote TIC, the real issue from an ecobiodevelopmental perspective is how well a parent's ACE score predicts their child's eventual ACE score (ie, are high parental ACE scores a risk factor for their children?). Most experts believe that parent and child ACE scores will correlate very well, but, at the moment, that has yet to be shown. So for now, parental ACE scores are not an "evidence-based" screen for the child's future health.	
Q: Can you share contact info for the task force member that is/will be facilitating the development of the website associated with trauma? I would love to collaborate some current efforts with you all on this.	I will defer to the AAP staff on questions related to website development.	Please feel free to contact Heather Fitzpatrick at hfitzpatrick@aap.org or 847/434-7642.
Q: Are your task force members a part of the ACES Connection (affiliated with www.acestoohigh.com)?	Yes, there are some of the project advisory committee members, including AAP staff, who participate in the ACEs Connection Network.	

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Q: Would you advocate for universal home visiting approaches and/or universal screening (prenatal and infancy) for risk of toxic stress?	This question is currently being debated by the AAP's Early Brain and Child Development Leadership Workgroup. In an ideal world with unlimited resources, universal home visits would be the norm, not only to screen for toxic stress but to proactively promote positive parenting and a "brain-healthy" environment. Given limited resources, however, it is probably more feasible to take a public health approach to toxic stress. Primary prevention efforts could include community-wide, consistent messaging (similar to the Communities that Care Program) and anticipatory guidance on the importance of both parental/caregiver mental wellness and making young children feel safe through stable, nurturing relationships. Secondary preventions could include home visitations and/or the VIP (video interaction project) for those families at high risk for toxic stress.	
Q: Is there a parenting format for classes that can be used by social workers?	There are several evidence-based interventions. Triple-P (Positive Parenting Program) and the Nurturing Parenting Program are two examples.	
Q: During the Q&A, it would be helpful to talk about the kind of interdisciplinary collaborations that may be needed to support/create the social emotional safety net/universal precautions.	I would point to the Communities That Care (CTC) Program as an example. Although CTC is an evidence-based intervention to improve adolescent behaviors like substance abuse, smoking, and violence, the social development model of providing consistent, community-wide (OB offices, medical homes, early intervention, WIC, early education and child care centers, mental health professionals, community support centers, and houses of faith) messages to promote safe, stable and nurturing early relationships is promising.	
Q: A list of reference articles would also be helpful. Thanks!	For the ACE Study, please see www.acestudy.org and www.cdc.gov/ace/index.htm. For a brief description of epigenetics and how early childhood experiences influence the life course, see Gluckman, Hanson, Cooper and Thornburg, 2008, NEJM, 359:61-73. For a brief review of toxic stress and the neuroscience, please see the AAP Policy Statement and Technical Report. A synopsis of Maslow's Theory on Needs can be found at en.wikipedia.org/wiki/Maslow's_hierarchy_of_needs. The figure on hippocampal development came from Luby et al., 2012, and can be downloaded at: www.pnas.org/content/early/2012/01/24/1118003109.full.pdf.	Provided link to policy statement and technical report on toxic stress.
Q: Do you know of any research comparing teenagers that are or seem to be very mature, but have had to "grow up fast" because of environmental factors?	I am not aware of such data	
Q: Is there data that measures adults who appear to survive toxic childhood fairly well and then go into a downward spiral if their adult environment or health deteriorates?	The concept here is allostatic load, and it is discussed succinctly at: en.wikipedia.org/wiki/Allostatic_load.	
Q: How do you plan on reaching out to those families that do not have a PCP or Medical Home due to being not/un insured?	Beginning with the Pediatric Medical Home makes sense because we know the majority of children (80% or more in some locations) get their immunizations on time. From a public health perspective, it probably makes more sense to find ways to get these children insured and into a medical home (through expanding Medicaid, SCHIP, etc.) than to develop an entirely new program with a different infrastructure. There are very few professional venues that frequently interact with the families of children under the age of three.	
Q: How would you respond to pediatricians that feel screening for community violence and bullying, while important, is not prioritized because of the limited time and lack of resources. Is identifying these children later in childhood beneficial, even if pediatricians cannot change the child's environment or have an impact on early parenting?	The first step here is education. Given the ever expanding evidence that 1) psychosocial issues are every bit as biological as lead or nutrition and 2) early childhood adversity has life long consequences, one could easily argue that the underlying problem IS PRIORITIZATION! Identifying a struggling family or a toddler who is being bullied and successfully intervening is more likely to improve that family's and child's long term wellness than almost anything else that we do as pediatricians! As for the lack of resources, pediatricians are well positioned community leaders to advocate for investments in the development of those resources. The brain's declining cellular plasticity tells us that while it is never too late to try, early interventions are more likely to be successful.	

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Q: How do you intervene with pregnant and youth with children in foster care?	First you need to successfully address the parent's trauma. In doing so, they may become better, more nurturing parents and break the intergenerational cycle of early toxic stress.	
Q: Are there any brief parenting improvement programs that have been tested and used in the context of well child checks or brief office visits? We have looked closely at Triple P Primary Care but this is a 4 session model that seems to have limitations for relatively brief physician visits. Thank you.	Many evidence-based parenting programs in primary care utilize staff (bachelor's level child/family specialists) other than physicians, which inevitably leads to concerns about reimbursements and fiscal responsibility. Because there ARE office based programs that have been shown to proactively improve parent-child interactions (like the Video Interaction Project), it behooves the pediatric community to 1) develop innovative ways to fund these programs (e.g., public-private partnerships; private grants from foundations or the business community), and 2) educate payers about the ability of these programs to lower medical costs in the future. Ultimately, a financial incentive from payers is likely to be necessary for universal adoption. The current emphasis on wellness care and accountability in the ACA are hopeful signs that such financial incentives may now be more plausible.	
Q: Andy, help us understand why children living in very toxic environments like growing up in a war zone do not all have toxic stress reactions?	Two thoughts here. First, there is a growing evidence base that some children are biologically/genetically more sensitive/susceptible to the environmental/experiential context than other children (see www.hsperson.com/pages/Ellis_2008_Biological_Sensitivity_to_Context[1].pdf for a brief description of this concept). Secondly, if their biological (food and sleep), relational (stable connections to a nurturing adult), and self-esteem/self-actualization (a sense of control and accomplishment) needs are met, they may still do well despite not having their safety needs met consistently. Those relational and self-esteem/self-actualization skills may allow the physiologic stress response to threats of bodily harm to be brief, effectively buffering against the stress associated with a lack of safety.	
Q: What can we as non-medical professionals (i.e. social workers, CPS workers) reference when working with pediatricians to bring their attention to this opportunity?	I would point them to the ACE study (at www.acestudy.org and www.cdc.gov/ace/index.htm) and to the AAP's Policy Statement and Technical Report on Toxic Stress.	
Q: Is there evidence that ACEs occur more frequently in children of unplanned pregnancies? Should antiviolence activities extend into area of planning families?	I am not aware of such data	
Q: Question for Andrew - This is very pediatrician-focused, but what kind of role can local health departments play in mitigating the effects of violence?	I believe that public health officials and pediatricians should work closely together to spread a consistent message on what toxic stress is, how it alters life course trajectories, and how a public health approach to toxic stress can improve wellness, decrease healthcare costs, and increase academic success. I would again point to the Communities That Care program as a model of how the medical, public health and business communities could collaborate.	
Q: What can we do for adolescents who may have not had any of the support as children, especially children in gangs or who are incarcerated?	Because the brain is still plastic until the mid twenties, we need to take remediation approach (teaching healthy, adaptive coping skills) instead of a retribution approach (pay your debt to society).	
Q: Are there stress screening tools for children?	Yes, but it depends on whether you are screening for the consequences of toxic stress (PTSD, anxiety, depression) or risk factors for toxic stress (like food scarcity, unsafe housing, and potential threats to nurturing relationships like extreme poverty, parental mental illness or substance abuse, and domestic violence).	

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Q: I like the way that you present the psychosocial stressors and other salient features of the ecology are every bit as biological as nutrition or lead exposure.....is there thought to a universal assessment being used in doctor offices?	How do you effectively assess a child's entire psychosocial ecology? I'm not entirely sure that you can - particularly since child development, parental functioning, and parent-child attachments are such dynamic, moving targets!! But we should probably begin by doing social-emotional surveillance at every visit (is there a problem in the attachment/family relationship here?), and then consider standardized screens for the most common psychosocial risks (like food scarcity, unsafe housing, and potential threats to nurturing relationships like extreme poverty, parental mental illness or substance abuse, and domestic violence). There are some standardized screens to assess childhood social-emotional development (e.g., ASQ:SE) and global functioning in childhood and adolescence (e.g., PSC), but assessing the psychosocial "milieu" in a standardized manner may prove to be very difficult because it necessitates an on-going evaluation of parent/caregiver functioning and the nature of their attachment to the child. Some would probably argue that the Video Interaction Project is the best tool currently available to assess and address issues regarding parent-child interactions.	
Q: What are your recommendations of how to engage pediatricians in a public health approach within a community?	First, I would point them towards the ACE study (at www.acestudy.org and www.cdc.gov/ace/index.htm) and to the AAP's Policy Statement and Technical Report on Toxic Stress. Then, I would point out that, while they cannot do this alone, a collaborative, community-wide effort could yield significant dividends for everyone involved.	AAP Policy Statement on Toxic Stress: http://pediatrics.aappublications.org/content/129/1/e224.full?sid=23890cdd-dd37-48d6-9b5a-3c15ea20510b AAP Technical Report on Toxic Stress: http://pediatrics.aappublications.org/content/129/1/e232.full?sid=23890cdd-dd37-48d6-9b5a-3c15ea20510b
COMMENTS (No official response are being provided to comments, but participants may find some of the suggestions from other participants useful)		
Q: I suggest that the group strengthen the discussion of community-wide approaches. The pediatrician doesn't have to do it all. Talk more about what nurse-family partnership can do, family support centers, child-care providers, health departments. Talk about early childhood interagency councils to bring these elements together for the good of all kids.		
Q: Early intervention programs need to change from their emphasis on childhood learning and include social-emotional help and family support.		
Q: Important to devise ways to include parents' points of view in program planning. Also cultural issues.		
Q: Another pretty wide outreach program is WIC. It sees millions of kids and some have poor connections to health care.		
Q: Let's also work on minimizing wasted time in well-child appts like a physical exam at every visit Improve data collected in electronic medical records (we use Nextgen and many WCC data in it are useless		
Q: Looking at unintended pregnancies, which are 30-40% of all pregnancies, it's important to distinguish between poorly timed (didn't want to become pregnant right now) versus unwanted (didn't want to become pregnant at any time). Most parents of poorly timed pregnancies do OK; parents of unwanted pregnancies are more likely to have psychosocial problems.		
Q: Regarding reinventing the wheel, take a look if you haven't at the CSEFEL model (Center for the Social and Emotional Foundations of Early Learning), a public health pyramid model for infants and young children used in community-based family- and child-serving programs.		
Q: WIC is also a good place to make connections to supportive programs.		
Q: As a CASA I see the effects daily --- thank you for this information and for encouraging the doctors to work with the parents. The doctors might recommend the book "The Whole Brain Child" to the parents. The slides came without a delay and the audio was good on the computer.		