

## **Adverse Childhood Experiences: Early Experiences Do Matter**

### **Track C – Family and Community Partnerships**

#### **17<sup>th</sup> Annual Virtual Birth to Three Institute**

You can find the webcast titles here: <http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/btt/descriptions.html>

These are the titles of each track:

- A. Inclusive Child Development
- B. Child Health and Prenatal Services
- C. Family and Community Partnerships
- D. Management and Professional Development
- E. Home Visiting and Family Child Care

[Music]

Angie Godfrey: Hello, I'm Angie Godfrey, Infant and Toddler Program Specialist at the Office of Head Start.

Jennifer Boss: And I'm Jennifer Boss, Director of the Early Head Start National Resource Center. Welcome to week three of our virtual Birth To Three Institute. I hope you're enjoying vBTT thus far. I know that we certainly are.

Angie: Last week was tremendous. I love the fact that the entire track focused on pregnant women and their families. Before we move on, I want to share a couple of key messages from that track. One: Fathers play an important role during the mother's pregnancy and should be engaged early and often throughout the pregnancy. Two: A baby's capacity to learn begins well before birth. Three: The second-week post-partum visit is a wonderful opportunity to expand and strengthen the relationship with the family.

Jennifer: This week is Track C: Family and Community Partnerships. We begin our track with the Plenary presentation titled, "Adverse Childhood Experiences: Early Experiences Do Matter." Our presenter for this Plenary is Dr. Vincent Felitti, one of the Co-Principal Investigators in the "Adverse Childhood Experiences Study," commonly referred to as the ACE Study. The ACE Study is one of the largest investigations ever conducted on the associations between childhood maltreatment and later life, health and well-being. More than 17,000 patients who are undergoing routine health exams volunteered to provide detailed information about their childhood experiences of abuse, neglect, and family dysfunction. Dr. Felitti will discuss data resulting from their participation. I can't wait to hear more about this study and how it relates to the important work that we do in Early Head Start.

As a reminder, the format for this webcast will be a 30- to 40-minute plenary addressed by Dr. Felitti, followed by a 30-minute panel discussion with respondents. Then, you're invited to join to us for a live question and answer audio call with Dr. Felitti. The call-in number for the Q & A will be given at the end of this webcast, so, don't forget to make note of any questions you may have as you watch the program.

Angie: Today's webcast will be followed by two webinars later in the week that will discuss specific techniques for working directly with families. The first webinar, "Using Motivational Interviewing Techniques to Build Collaborative Partnerships with Families," will introduce key concepts of motivational interviewing to support positive change and partnerships with families. It will be presented by Rachel Galanter and Ennis Baker. For the past 12 years, Rachel has worked as a Family Support Specialist and Program Manager at the Durham Exchange Club's Family Center. She is a member of the Motivational Interviewing Network of Trainers and is committed to empowering families to build on their strengths. Ennis is a Licensed Clinical Social Worker who specializes in early childhood, and who has served in a variety of roles, focusing on at-risk children, ages birth to 5, and their families. He implemented motivational interviewing techniques in the Orange County Early Head Start Program in Raleigh-Durham, North Carolina.

Jennifer: The second webinar, "Partnering with Families Who Are Coping with Adversity," will address how Early Head Start staff can help families to identify and nurture the resources within their family to cultivate resiliency during difficult times. This webinar will be presented by Bruno Anthony and Elizabeth Lujan. Bruno has provided behavioral health services in Head Start, and has developed and evaluated programs to help teachers and families support positive development. Elizabeth is a psychologist at the University of California-San Francisco, and brings a wealth of experience and knowledge in working with families and children who are coping with adversity.

Angie: Prepare yourselves for another week of strong content. It is an opportunity for a great learning experience and we look forward to speaking with you again next week, as we continue vBTT. And now we leave you with Dr. Felitti's presentation.

[Music]

Dr. Felitti: Well, it's nice to be here with you all this way. I'm Dr. Vincent Felitti, one of the two Co-Principal Investigators of the Adverse Childhood Experiences or ACE Study. The ACE Study actually could be summarized by the question that's implicit in the two photographs on this slide.

[Silence]

Dr Felitti: If someone were to give you this newborn infant with this extraordinary potential, and ask you the question: "What do you have to do to develop that infant into the person 20 years later lying unconscious on the sidewalk, overlooked by the world, what would you have to do?" That's what this is about. It has relevance to all of us. The study began when this patient showed up in an obesity program we were running in 1995...in 1985 and asked if we could help her with her problem. Our first mistake was in accepting her diagnosis of what the problem was and we said, yes. And in 51 weeks, took her from 408 to 132 pounds, and, perhaps, understandably thought: "My God, we must really know what we're doing." She forced us to realize...our teacher forced us to realize that essentially we knew nothing about what we were doing, but merely were in possession of a powerful technology that of supplemented absolute fasting. And slowly, we came to see that there was a real analogy here to smoke and house fires.

Typically, when a house is burning, what you see is the smoke billowing out, the flames inside...the cause...the causal issue, are not visible. And so if you didn't know much about the relationship of smoke to fire, you might think that the smoke was the thing to be treated and bring big fans to blow it away, except the house burns down faster that way and pretty soon homeowners flee the treatment: A very common problem in addiction programs and what happened here. Here's this woman's weight curve. You see it looks like a ski jump. She gets down to 132 in 51 weeks, stays there a few weeks, and then in one 3-week period, regains 37 pounds and is quickly over 400 pounds again, actually faster than it took to lose the weight. And she disappears for 12 years before returning, but not before learning about a long-term incest history with her grandfather underlying her obesity. And it was she who helped us discover other sexual abuse cases and then other forms of child abuse, and then all the patients who grew up in massively dysfunctional households.

Ultimately, this led to a meeting with some people at the CDC and to the beginnings of the ACE Study which were really designed to see whether the things that we were discovering in our obesity program about tremendously traumatic childhood experiences were at all prevalent at a general population and, if so, how they played out over time. The outline of the study is what I've depicted here. The blue box in the middle shows where people came through an unusual program that we had providing very comprehensive biomedical, psychological and social evaluation to about 58,000 people a year in one setting. And so, when they came through for that, we asked 26,000 consecutive of them, if they would help us learn more about how experiences in childhood played out decades later in adult life. Seventy-one percent agreed, so we had our study cohort of over 17,000 patients, basically you and me. I mean, that's an important thing to understand. This is not some group across town; this is, basically, you and me. The average age person was 57, 80 percent white, including Hispanic, 10 percent black, 10 percent Asian, 74 percent had been to college, etcetera.

So, we matched current health status against 10 categories of adverse life experience in childhood, and they were selected empirically because we kept stumbling into them so frequently, and then have been following that group forward for the past 18 years, matching what happened 60 years ago roughly, against current pharmacy utilization, emergency room visits, doctor office visits, hospitalization, and death. Keep in mind that this is really you and me that we're talking about.

Here are the 10 categories that we selected, three of abuse, major emotional abuse, basically recurring humiliation, 11 percent acknowledged by this population. Major physical abuse, I'm not talking about spanking; I'm talking serious beating, 28 percent. Contact sexual abuse, 28 percent by women, 16 percent by men, 22 percent average for this group. Major emotional neglect, 15 percent. Major physical neglect, 10 percent. Growing up in a home where one of the members of your household was an alcoholic or a drug user, 27 percent. Losing a biological parent for any reason before the age of 18, 23 percent. That was interesting because we saw that most disruptively was maternal abandonment. I mean, that was really the end of a kid's life. It might...might take a while for that to become clear, but that was clearly the most destructive...least destructively by parental death. Because that at least allowed a protective mythology to be created. You know, my mother would have cared for me if my father would have protected me, if. Most commonly, obviously, by divorce, which interestingly is an untouched topic, I suspect, because so many of us have been divorced, that it's been an uncomfortable topic to approach. Growing up in a home where one of the members of your household was chronically depressed, suicidal, mentally ill, or in the state hospital, 17 percent. In a home where mother was treated violently, 13 percent. In a home where one of the members was imprisoned, 5 percent. And I remember thinking, oh, I mean, that's really not extremely high. And then I remembered two prominent physicians I know whose sons are in the state penitentiary. Now, that don't talk about that, of course, and so most people don't know.

So, this was a real eye opener. And equally surprisingly was the fact that these 10 categories were essentially co-equal in impact. That, too, was a real surprise. We were dealing with mountains of data, literally 400,000 to 500,000 pages of data between questionnaires and physical exam forms and laboratory slips and so on. We needed some way of simplifying this, so we created an ACE Score, which was the sum of the number of categories, not events or incidents, but categories of events that occurred in that individual's life, and it could range from 0 to 10. And we found that only 33 percent had an ACE Score of 0, no exposure to any of those 10 categories, and that 11 percent, one in nine of us, were exposed to five or more of those categories. And we saw that women were 50 percent more likely than men to have an ACE Score of five or more categories.

So, what that means from a physician standpoint is that every doctor in the country is going to see two ACE Score 5, or higher, patients every day. And they'll be unrecognized other than that they'll be the most difficult and intractable cases of the day, because they're not going to bring it up on their own, and we've all been taught that it wouldn't be polite to inquire.

Let me summarize what we found to give you some skeletal structure to hang the information on that I'll present momentarily. The ACE Study is a retrospective and prospective analysis in 17,500 middle-class adults of the effects of 10 categories of adverse life experiences in childhood. The very existence of these experiences was found to be quite unexpectedly high, although unrecognized because they're lost in time, and then they're further protected by shame and by secrecy and by social taboos against discussing certain realms of human experience. Their effect roughly a half century later, is powerful and proportionally related to the number of categories of adverse life experience in childhood, and thereby is a major...a determinant of emotional well-being, of so-called health risks, of mental illness, of occupational performance, of social malfunction, of bio-medical disease, and of premature death. And interestingly, we found that a small change in what we do has demonstrated major benefit. We'll come back to that.

This woman has been kind enough to offer to help us begin. No one meeting her would suspect either her childhood history or her problems, and thus no one would ever ask, I mean, my God, you look at her, she's well dressed, articulate, etcetera, has a good job, you know, she's doing well. So, the avoidance of routine inquiry is a common and basic error that we make in medicine and related fields. Let's listen to what she has to say.

Woman: Can you tell just by looking at me that I was an abused child? Can you tell that I was sexually abused routinely? That I was neglected, starved, beaten? Probably not. You would have to ask in order to find out and that's not the sort of thing that people typically ask about. The downside of having this kind of childhood is that it translates into health problems in adulthood, at least in my situation it seems

to have done. I'm now recovering from my third battle with cancer...not the same cancer, three different kinds of cancer. I've had chronic pelvic pain, migraines, you...the whole laundry list of medical complaints, all of those sorts of things that are very difficult for physicians to figure out. Growing up that way instills a constant fear, a constant state of turmoil that's just under the surface of a...a veneer that's fairly thin. [Sighs] Little things become scary in an atmosphere like that, and once you've internalized all of that, it's very difficult to let go of it.

Dr. Felitti: She has problems with chronic depression and anxiety, so let's look at that as an outcome. And what we see in this graph is that self-acknowledged chronic depression in adults is dramatically and proportionately linked to adverse life experiences in childhood. You see how as the ACE Score goes up, the red bars for women, indicate that the...that the self-acknowledged prevalence of chronic depression goes up in a step-wise proportionate manner, so that at ACE Score 4 and higher, you're seeing almost a 60...60 percent prevalence of chronic depression in women, men, about 35 percent. If we look at self-acknowledged suicide attempts, we see an even stronger relationship. I mean, this is really rather traumatic. I should tell you that ACE Score 6 is not demonstrated because it doesn't fit on the slide. At ACE Score 6 and higher, there is a 30- to 51-fold, 3,000 to 5,100 percent increase...in the likelihood of later suicide attempts, as compared to ACE Score 0. The epidemiologists at the CDC tell me that numbers of this magnitude are rare, typically seen once in a career. This pattern, by the way, I should tell you, has a significant bearing on our current problems with suicides in the military. And here we are roughly half century after the fact, looking at the relationship of current prescriptions for antidepressant medication related to underlying ACE Score from roughly a half century back. You see the same step-wise proportionate increase.

So, it's pretty clear that there's a repetitive pattern here, and it would appear that depression has deep roots often going back a half century into childhood. We looked at the relationship to impaired memory. "You know, it's funny, Doc, I don't remember anything from when I was 10 to about when I was 14." Focal amnesia basically, and you see the same step-wise relationship to underlying ACE Score, which suggests that our outcomes may even be a bit worse than the evidence suggests, because some of the childhood events are going to be protected by amnesia. Amnesia, of course, is a mechanism of dissociation which itself is a high-grade marker for traumatic abuse.

Here's an interesting guy. A very bright man, an amateur psychopharmacologist in a way, a semi-pro saloon fighter as well. He will speak of three addictions that he has: Alcohol, tobacco and crystal meth. The background story is this: When his parents...when he was 2, his parents divorced, never saw his father again in his life. Mother remarried at 5. For whatever reason, his stepfather saw fit to beat him pretty much every day. He remembers one day when he's 8 and walking to school, the thought crosses his mind, "No one is ever going to be there for me in my life." When he's 20, he's imprisoned in Rhode Island for attempted murder of his stepfather. Gets out ultimately, becomes a good citizen, has a

responsible job on frontiers...major construction projects, and so forth. Home is still not a place to be fully trusted. In a different era, this guy might have been a cowboy or now might be working on an oil rig or somewhere safely far from home. He has some important insights about the functionality of addictions which we conceal by describing them as dysfunctional behavior. Listen to what he has to say. This is a man with meaningful things to say.

Man: Tomorrow 25 years, dry me out some, poor childhood experiences with drugs, alcohol, cigarettes. Got rid of the drugs, got rid of the alcohol. Next thing, I got to get rid of is the cigarettes. And, I had no idea that the nicotine played such an important part in keeping that door closed.

Dr. Felitti: In keeping the door closed to?

Man: The memories that I've blocked out with all these years with the alcohol and the drugs.

Dr. Felitti: So, you see what's happening to you now as related to what happened to you decades ago?

Man: Yep. I've found a way to block the emotions and the memories.

Dr. Felitti: With...?

Man: Drugs, alcohol, cigarettes.

Dr. Felitti: Addiction, that is to say, the unconscious compulsive use of psychoactive agents, is conventionally thought to be due to mysterious characteristics of certain chemicals like methamphetamine or heroine or alcohol, nicotine...something about the molecular structure. I used to believe that. What we found was exactly the opposite, that addiction highly correlates with characteristics intrinsic of that individual's childhood experiences, a totally different concept and here's the evidence. Take smoking. I don't know what it's like where you live, but in San Diego, it is very difficult to smoke. I mean, my God, you can't even smoke on a public beach anymore.

So, what you see matching the likelihood of current smoking against underlying ACE Score, is that the probability of being a smoker in this environment, notably hostile to it, is directly proportional to

underlying ACE Score...to what when on in childhood. Very different concept. I mean, this doesn't fit in with conventional views, you know, that kids smoke because of billboard ads or peer pressure, etcetera. It does fit in with knowledge about the psychoactive benefits of nicotine. The fact that nicotine has potent anti-anxiety activity, potent antidepressant activity, appetite suppressant activity, but since the Surgeon General's report in the 1960s, we've forgotten all of that, and hence, have been playing in a difficult game with only a half a deck, and maybe that has something to do with why a significant minority of people still smoke, in spite of ever increasing public health efforts to eradicate smoking. In other words, we're not treating the core problem, we're trying to treat somebody's attempted solution to core problems that we know nothing about.

We look at self-acknowledged alcoholism here. You see this rather dramatic relationship to ACE Score. Question we used was simple: "Have you ever considered yourself to be an alcoholic?" Pretty impressive relationship. And here, when we looked at self-acknowledged injection drug use; once again, ACE Score 6 does not fit on the slide; at ACE Score 6 there is a 4,600 percent increase in the likelihood that that individual will become an injection drug user, as compared with an ACE Score 0 individual.

Let's go back to our original patient who, years after regaining all of her weight, had bariatric surgery, stomach bypass, etcetera, whatever you want to call it. At a point where she had lost only 96 pounds, which interestingly to me was not clearly visible, she became intractably suicidal, had five psychiatric hospitals and three courses of electric shock in the coming year to regain control of the situation, and here she explains why that happened and we begin to see how what may be viewed in public health as a problem, may, in fact, be viewed by the patient as a solution. And mistaking somebody's solution for their problem is a serious error that we commonly make. This public health paradox is what makes preventive medicine and public health so difficult. In other words, we often end up treating the highly visible smoke, not understanding that the underlying fire is what needs our attention. She'll speak for herself here.

Woman: I wasn't really handling the weight loss too well. I mean, it came off too quick and, I just felt like I was losing my protective wall. It was like, you were right, there was no going back. I...I had...wasn't able to use food as, my way to get fat again, to have my solution back. It's like I had lost my solution and it wasn't...I was having a hard time trying to find other solutions to deal with, underlying issues of obesity versus just...using the obesity as my wall.

Here is a man's view of things. This man became obese as a child, after his parents divorced and he had to live with his violent, alcoholic grandfather, so that his mother could work. He vividly recalls eating for solace, kind of reminiscent of our phrase, "comfort food." And as he grew obese, he discovered that

obesity offered advantages. And we know that at some level. You think of our use of the expression, "throwing your weight around." He speaks clearly to that point.

Man: I ate because I was hungry, and I was...when I look at it, it was just a...a place for me to, feel safe. As a child, I remember...there was a point...I would probably say, all the way from kindergarten to, God, I don't know what grade, but I used to get beat up all the time. All the time. And, when I got the weight on, it didn't happen.

Dr. Felitti: Let's now look at some disturbed social outcomes related to adverse childhood experience. Here, we're looking at the relationship of ACE Score to the likelihood of perpetrating domestic violence and rather surprisingly, we see that the effect on women is about the same as it is on men. We're used to thinking of women as being the victims as violence, but this shows that they're equally likely to be perpetrators. But because their victims are typically their children, that story is largely untold. Here, we're looking at how this plays out in the workplace. Now, toxic environments are real enough at some worksites, but not nearly as prevalent as toxic childhoods are at those worksites.

First set, you see the relationship of ACE Score to absenteeism. Second set, you see the relationship of underlying ACE Score to serious financial problems later in life. That's kind of interesting, because there we're looking at evidence that, that poverty should be looked at as an outcome of other more basic causes, rather than a primary cause itself. Now, whether that holds up in Third World countries, I don't know. But certainly in the United States what we see here is pretty clear. And last is the relationship, self-acknowledged, to not being able to perform one's job properly to underlying ACE Score.

Let's switch now to outcomes in biomedical disease. Here, we're looking at the relationship of ACE Score to chronic obstruction pulmonary disease...emphysema most...most commonly. And this is an important and complex point, the conversion of life experience into organic disease. Now, you might properly say, well, some of this is going to be explained by smoking as a coping device leading to COPD, and that's true. But there's more. Because we found that for smokers at the same level, in other words, you know, one pack a day, two packs a day, whatever, the likelihood of COPD is then proportionate to underlying ACE Score. And, in addition, we found that very strong relationships are reported between ACE Score and a host of biomedical conditions, including liver disease, autoimmune disease, and coronary artery disease, even after controlling for conventional risk factors, such as smoking. I mean, how does that occur?

Most of us know, since the Framingham Study, that there are certain well recognized risk factors for coronary artery disease, heart attack, angina pectoris, etcetera, such as, smoking, cholesterol, obesity,

diabetes, hypertension, etcetera. Most of us don't know that when you look at populations of people who have coronary artery disease, about 10 percent to 12 percent of them don't have any of those underlying risk factors, and the question sensibly comes up, well, how did they get it? And here, there's a second major pathway that relies on the effects of chronic, major unrelieved stress over very long periods of time, causing dysregulation of the hypothalamic-pituitary-adrenal axis, and the release of so-called proinflammatory cytokines or proinflammatory chemicals that cause inflammatory changes in the lining of the smallest blood vessels, causing them to shut down and to convert to scar tissue, whatever little piece of organ they were supplying.

The first case I showed you, our poster patient if you will, a woman who never smoked, died of a condition, primary pulmonary fibrosis, now recognized to have some portion of its prevalence attributable to the release of these proinflammatory chemicals. There's a third pathway that's only beginning to be studied, in fields of psychoneuroimmunology and of epigenetics. Early in the study, we noticed that as ACE Score increased, the expected age distribution of our patients reversed, and high ACE Score patients started disappearing. As a result of the prospective portion of the study, where we're following people forward now in the 18th year more or less, we discovered and have a paper out in the journal circulation that at ACE Score 6, there is a shortening of life expectancy by almost 20 years compared to ACE Score 0, and that's why the ACE Score patients were disappearing.

People don't just get over these things. Time doesn't heal. Time conceals and people die.

Here, we're looking at two PET scans, a very sophisticated kind of x-ray, depicting biochemical activity superimposed on anatomical structure. These are PET scans of the brains of two 3-year-old little boys. The one on the left, a normal American kid, the one on the right, a little boy taken from a Romanian orphanage, institutions that are well recognized as being notable for the extreme neglect imposed on their inmates. And what you see in the right-hand PET scan is large areas of brain that don't have any color in it, a profound lack of biochemical activity. And I don't think it's going to tax anyone's imagination too much to think that maybe at age 3, when brain is being built, this lack of biochemical activity is going to shape the kind of brain that's being formed. In other words, what we're looking at here is a depiction of the hard wiring of life experience and at a time when none of the causality is going to be remembered.

We'll summarize what we've been talking about, thus far, this way. You have this large base of individuals with adverse childhood experiences, overwhelmingly unrecognized, producing, we now know, some disruption in brain development early in life, producing various kinds of impairment; it might be social in one kid; it might be emotional in another; it might be learning in another. By the time they become teenagers, they have enough freedom to try to do something to feel better, and eating

helps, and nicotine helps, and alcohol helps, and sex helps, and methamphetamine helps. And as time goes by, the things that help initially begin to cause their own problems and so in midlife you see people becoming disease disabled, having all sorts of social problems, and a number of them die early, the whole sequence being lost in time, and then further protected by shame and by secrecy and by social taboos against exploring certain realms of human experience.

So, what we can say, in summary, is that adverse childhood experiences are the most basic and long-lasting cause of health risk behaviors, of mental illness, of social malfunction, of disability, of biomedical disease, of death, and obviously of healthcare and social costs. I've given you some evidence to illustrate each of these. The rest is depicted in the 70 or so publications that have been, thus far, derived from the ACE Study, but I would urge you to find out for yourselves, namely, by routinely inquiring about these issues. I'll remind you of this public health paradox: That what are conventionally viewed as public health problems are often personal solutions to unrecognized adverse childhood experiences. I mean, this is a profound idea that underlies the failure of our many public health approaches, to mistake someone's attempted solution as their problem. And it's important to realize here that in all of medicine there are only three sources of diagnostic information: Patient history, physical examination, and laboratory studies. Of these, patient history is the most productive, leading to diagnosis, about 75 percent or 80 percent of the time. It's also the least likely to be comprehensively done well for any number of reasons, including time. So, we integrated these so-called trauma-oriented questions into our already lengthy medical history questionnaire that's filled out at home, and we saw that the depth and breadth of what can be learned in intimate detail by a well-devised questionnaire is really quite remarkable and exceeds what otherwise would be attempted in face-to-face interviews with a stranger.

We added questions like these: "Have you ever lived in a war zone? Have you ever been a combat soldier? Who in your family has committed suicide? A very different question from "has." "Who in your family has been murdered? Who in your family has had a nervous breakdown? Were you ever molested as a child, tortured, raped, etcetera?" This had a dramatic effect and, interestingly, it was well accepted by patients. In our old manner of working without the trauma-oriented questions, going through for comprehensive medical evaluation was associated with an 11 percent reduction in doctor office visits in the subsequent year. We were very pleased with that.

When we added trauma-oriented questions, that was associated with a 35 percent reduction in doctor office visits in the subsequent year, and a 11 percent reduction in ER visits, and that was in a sample of 125,000 adults. You don't see samples that size very often.

So, reducing by a third, the perceived need to see a doctor is a remarkable empowerment; so, if you were to ask: "Well, what can we do today?" I would say it would be this: Acknowledge the reality of

"yes" answers by asking: "Tell me how that has affected you later in your life. I see on the questionnaire that..." "Can you tell me how that's affected you later in your life?" "We have existing systems... they're not perfect, but we have existing systems to help with current problems, but we need to develop systems for primary prevention, for keeping these things from happening in the first place, because the magnitude of what we're talking about is vastly greater and more powerful than anything any of us ordinarily understands to be. If you're interested in further information about this, here are some sources for you.

So, I hope you will pursue this on your own, by finding out in your own work how this plays out and I thank you for inviting me here.

[Music]

Terra Bonds Clark: Good afternoon. I'm Terra Bonds Clark, Director of Special Initiatives at the Early Head Start National Resource Center. Thank you for joining us for today's webcast. We just heard a presentation from Dr. Felitti about the connection between adverse childhood experiences and later life health and well-being that illustrates how important our work in Early Head Start is. Now, I'm going to be moderating a discussion with two wonderful panelists to build on what we learned.

First, I'm delighted to introduce Cleo Rodriguez, Jr., Executive Director of the National Migrant and Seasonal Head Start Association. And it's also my pleasure to welcome Amy Hunter, who directs the mental health section of the Office of Head Start's National Center on Health. As we get started, I'd like to ask each of you to think about what the information Dr. Felitti presented really means for Early Head Start, Head Start, and early care and education community as a whole.

The overarching message I came away with is that early experiences really do matter. In Early Head Start, Head Start, and other early care programs, we have a wonderful opportunity to work with expectant families and families with very young children, to prevent potential problems before they happen, or at least to intervene early to lessen the impact of these adverse experiences on young children's social, emotional, and cognitive development. The fact that Early Head Start and Head Start offer comprehensive services to the whole family, ensures that young children will grow up safe and healthy and have a strong foundation for learning and success later in life. When thinking about the "Adverse Childhood Experiences Study in the context of Early Head Start and Head Start programs,

I find there are three primary areas where we have a unique opportunity to impact early experiences for young children and their families. These areas are professional development, family engagement, and community partnerships. I'd like us to frame today's discussion around these three areas. Let's begin with professional development. Cleo, would you please talk a little bit about how professional development fits into a program's primary prevention efforts.

Cleo Rodriguez, Jr.: Sure, thank you, Terra. So, I think that professional development is really the starting point. I think that as programs start to explore ways that they're going to assist families and children with...with adverse childhood experiences, I think that they have to really create an agency plan for professional development. And, one that is very intentional, one that is comprehensive, but I also think that, that programs need to take a look at individual staff plans for professional development like and to really engage as a staff in terms of like, what's...what is going to be, what is going to best meet your need? What...what are we going to be able to do meet your needs to be able to... to work with the children, to work with families, to work within the community?

So, I think that it..it's a comprehensive approach that starts with your agency, and then also an individualized plan that starts with your staff persons. And then...but we can't, we can't overlook how important it is to...to care for the caregiver as we speak, because I think that often times our caregivers...our staffs come to...to the classroom with many adverse childhood experiences themselves, so it's like, what we can we do to make sure that... that we are helping our...our staff persons to...to be able to...to work through those... those situations so that they can minimize the number of those adverse experiences that they also bring into the classroom. And so I think that...that we really need to, to...to take a look at that and...and figure out ways of how...how do we...how we do help staff deal with those situations. And then I think the last point that...that I'd like to make is that...that any plan that we...that we create with a... with a program or with staff has to be very intentional and very comprehensive, and then I think also too, you have to have a continuous improvement plan, like...it's not a plan that you create in January and then you just put it on the table and you never come back to it. I think it's one that you've got to be consistently revisiting and updating. And so...so that you can make sure that you're always meeting the relevant needs of...of the staff, the agency, and the children and families.

Amy Hunter: Yeah, Cleo, the word that comes to mind when you're saying all that to me is this really idea of institutionalizing how we care for our caregivers. And, you know, some of the ways I think that we can do that in programs is, having perhaps reflective supervision practices in place, so that staff have a place to go and someone to talk to, where they can really sit back and reflect on these really sensitive and difficult subjects sometimes. Also, I think programs have EAP services in place or, employee assistance programs so that when things do come up for staff and they want to explore it a little more, in terms of working through their own issues and, you know, things that might be brought up from their

own childhood, they have a place to go where they can work through those individual, personal types of issues. Also, I think the mental health consultant plays a huge role in working with staff, doing the mental health consultation, talking with staff about how they talk to families and, again, what kinds of things come up for them and how they work with the children.

Cleo: I think so, and I think also, we can't forget, you know, when you talk about professional development too, and you...you have to figure out that there's a bunch of...there's a lot of cultural implications that take affect here. And we talk about the culture, not only of...of the individual staff, but there's a program culture, there's a staff culture, there's a classroom culture and then there's a family culture too. And...and so all of these, you know, can compete with one another and so how do we figure out how do we, learn how to make them complement each other or use them to complement one another.

So, I think that do we really have to take into consideration the different culture. And then, I think also too, in...in our Early Head Start programs we have, you know, the unique, populations that we serve. We have Migrant and Seasonal Head Start families that we serve; we have, American Indian and Alaskan Native pro...families that we serve. So, I think that all of these take...we must take into consideration as we're doing our professional development like, how do we customize and intentionally, individualize our professional development to meet the needs of the families that we're serving within our programs?

Amy: And it really makes me think of how important it is to help staff think about their...their own lenses that they bring. And how they can be aware of those lenses, so that they might be able to really see where the family is and what issues are issues for the family. Not necessarily making assumptions about, you know, these experiences that they learn about and how they may or may not have affected the family, but really understanding from the family's point of view how these experiences may impact their lives.

I think there's also a piece around, content related to professional development. So, you know, this very issue that Felitti is talking about, making sure all of our staff really understand how these early childhood experiences influence adult behaviors, adult mental health issues, adult health issues. I had the opportunity to see Felitti speak and it was...I could watch people in the audience really have those "aha moments" when it was live around, "wow, you know, I've been struggling with some of these issues, maybe weight, or smoking, or...and I didn't realize the connection, you know, into my past." And so I think for staff and for families, if we can really think about how do we provide that piece of education.

Cleo: Yeah, and I think again, we keep going back to the...the importance of really working with...individually working with staff members to really deal with these things, because again, these things come up over and over, again into the classroom. And so we want to minimize how those issues are surfacing in the classroom, because, you know, I fundamentally believe that any teacher that's in a classroom, any individual that's coming into contact with children and families, that they want to do the best that they can. And they want to bring their best forward. And so I fundamentally believe that and I think that we as agencies and as programs need to make sure that we're providing our staff with the tools and the resources that they need in order to...to be able to put that best foot forward. And I think you're right in terms of the...the issues that adults are dealing with now and connecting it to those adverse childhood experiences.

Amy: And I think, you know, not all staff realize and not all families realize how much their own well-being impacts the ability that they have to provide care for the young children. And so, you know, understanding how attuned young children are to everything that goes on in their environment and to those people who are providing care for them, and so how the adults are doing is, you know, foundationally important to how the children will do. And so making sure, you know, at a base level, everyone in the program understands that and then is able to communicate that message to families.

Terra: And tying back into that as well, I think the cultural piece that you talked about earlier and how the cultural belief really does impact how families process grief and also how they might interact with or share that experience or support their children around those traumatic experiences.

Cleo: And I think sometimes we have the misconception that a 2-week-old baby isn't responsive to their environment or to us as caregivers, that there's no...

Amy: That they're too young to understand. We hear that a lot: "Oh, they're too young, and they don't won't remember."

Cleo: And quite the contrary, they're totally in tune and...and so, we want them to be, you know, get that good...those good feelings from...from the caregivers that they have. And so I think... I love when you say "in tune," because I think that is a huge concept that we need to make sure that caregivers are in tune, so that they can be responsive to the individual needs of children.

Terra: Absolutely. Well, thank you, Amy and Cleo. You provided some great information about equipping staff with the knowledge, tools, and support they need to deliver to high-quality, comprehensive

services that lend themselves to the prevention and early intervention of adverse experiences for young children and their families. Now, let's move on to talk about the second area we mentioned earlier, family engagement. Amy, what are some specific strategies that staff might use to engage families to prevent adverse experiences or help them build the skills they need to rebound from traumatic situations they might go through?

Amy: That's a great question. Thank you, Terra. I mean, I think we go back to one of the recommendations that Felitti left us with around asking the right questions. But in order to ask the right questions we have to build from a positive relationship with families. So, I really would say that is the first, sort of strategy that we want to start with, is making sure that we're building positive, nurturing, responsive relationships, not only with children, but really importantly, with families. And, you know, Early Head Start is tasked with enrolling families who are at most risk or who most need our program, and many of those families come to us with previous experiences that perhaps haven't been so positive, that maybe have even been discriminatory or where they have felt shame or embarrassed. And so I think in Early Head Start, we really have this amazing opportunity to give them a different kind of experience, a different kind of relationship, than maybe, some of these families have ever had. And so to take that relationship then, internalize it over time, and then that will allow them to perhaps have different kind of relationship with their own children then they may have otherwise had.

Cleo: Well, and I think about, specifically some of our Migrant and Seasonal Head Start families, because I think that in some cases we have very limited time, right? And we still have many the same expectations and many of the same guidelines that are expected of, you know, regional Head Start, but we have them within our Migrant Head Start programs too. And in some cases, it could be a six, nine week program. And so I think that within any relationship that you're building, that you have to be, very intentional again. I think we keep coming back to that word, "intentional." And every interaction should be treated very critically, like this is a critical time and we need to make it count.

We need to make these interactions count and we need to be very purposeful in the interactions that we have. And I think you're right Amy, I think that we need to work with families where they are and when they get here, because you're right, I think they could have had a very negative experience. And it's our job and this is our job to help them understand that we can build a positive relationship. And even if you have a limited time, because families move. I'm not going on migrant families.

Amy: That's what I was going to say. Right. All..I mean, in all of Early Head Start, you know, we never know when a family is going to move or when a family has to be deployed, or...

Cleo: Right. Exactly. Exactly. And, so, we need to plant positive seeds now, because, we may not see them germinate tomorrow, but we may see them germinate at the next experience that they have, and...and giving them the security and the confidence that they have with service providers and building those positive relationships. But, I think that is the absolute foundation of any work that you're going to do has to start with that positive, relationship that you're going to build with families.

Amy: And it takes time, you know. I think that's one of the things we want to make sure people understand. You know, they may not see how the way they treated a family will impact that family, but then years later, it may be that they're remembering, well, that program treated me with respect. That program really heard me and really valued what I had to say. And the workers of the Early Head Start program didn't come with their own agenda, they really wanted to hear what was important to me, what I wanted from my child, what I wanted for myself. And that, you know, again that may be a unique experience. And it may take time, you know, I mean...you hear stories of, you know, family service staff or teachers, you know, really working at it every day.

Terra: Amy, something you just said that really, really struck me, in terms of how staff treat families and that respect and that listening, and I think that really models that parallel process that we often talk about in terms of how we are with families, that's how they will be with their children, that they will listen and be respectful and really understand where the child is in their development and be able to support that as well. So, I think there's a lot of that parallel process that happens there as well.

Amy: Absolutely.

Cleo: And, I think it also...it goes right back to that professional development too, because I think that this is all a part of that professional development plan, is how can we equip the staff with the tools that they need in order to be able to effectively build relationships and to understand how important those are.

Terra: Well, and right. So, I'll just jump in here for a second and take a moment to emphasize this idea that every interaction with the family is so important, and you talked about that earlier, Cleo. And it presents a unique opportunity, again, for us to make a difference for the child. Because of this, we always need to be thoughtful and intentional about how we engage families and partner with them to support their child's development. So, Amy are there some specific approaches that program staff might use as they work with families?

Amy: Absolutely, thank you. You know, we mentioned before, sort of this idea of asking the right questions. I think sometimes there's a misperception or a perception that we don't want to ask certain questions because it might be too intrusive or, you know, that's not our business, or you know, we feel like we're just, maybe going in too deep, you know, and that staff aren't equipped to...it goes back to professional development again. But, you know, to ask those really sensitive types of questions, but in fact, I think if we don't ask the questions, we may be really be missing an opportunity, in terms of knowing where the family's coming from, and knowing what the family's needs are, in terms of linking them up with the appropriate services. And, you know, you asked about strategies; I think there are some really, useful ways to ask the questions, so that we don't have just a checklist, you know, and go through, this is our form and we need to fill it out. But, in going back to that foundation of relationships, and then inviting families to tell their stories. And when families are comfortable and when they are trusting and when they realize that you really do care and your interest is genuine, and in fact, not just that you have an interest or curiosity about their story, but when they understand why you're asking the questions that you're asking, because there is a connection about their past experience to their current health and to their current behaviors, and that the Early Head Start program is a program that helps not only the child, but the family. And I think, often families don't necessarily know that when they come in. And so there's an education piece around that, and a way that we get that information that's..

Cleo: And I think this whole process of...gathering information from families through a family story as you say, is that...and I think you...you mentioned it there and I think it's a...a good point to reiterate is that: It's not prescriptive, right? It's very customized. Again, we come back to that word, "customized." It's very unique to this particular family. And it..and it should be a process that staff just allow to happen, right? You have a goal in mind of what the information is that you want to get from a family, that you want to learn and extrapolate from families, but you have to allow it just happen. And just, you know, and you can guide it along the way, but I think you have to...you can't be like it's just...it's not a checklist. It is very much open-ended questions; it's very much allowing families to share with...at the level that they're comfortable sharing. Because you're right, it's that relationship when they feel more comfortable; you may not get everything in the first time that you sit down with families. It may take a while before you get, you know, more and more of those experiences that are really starting to impact behaviors now. So, I think again it's like you say; it takes time. It takes time.

Terra: Well, I was just going to say. One of the things that I thought of and I tied it back to something you said earlier, Cleo, when you were talking about the importance of culture. And when we think about working with a variety of families that come and bring their culture to the table, whatever that may be, and certainly working in communities like American Indian, Alaskan Native communities, we really hear families stories and want to understand and learn about them and really are respectful of what they bring to the table, but by allowing them to share those stories, that's really how we make a connection, and how we really tie in with families around this family engagement piece, I think. Right. And I keep going back to another thing that you said, here's those "yes" questions. Because, sometimes you are going to get "yes" to some of these difficult questions, and it's like: Are we equipped to deal with that

and what are the next steps once we get to that "yes" question. And I think it goes again, back to professional development.

Amy: But, and it's...it's funny, because I've heard that as a reason not to ask some of the questions: "Well, we don't know what to do with the information when we get it." And so it really, goes back to being prepared, you know, for the answers that families might give us, if we have the trusting relationship.

Terra: Absolutely. Wow, so we've covered a lot of information and I know we've given programs quite a bit to consider in all that we've discussed, thus far. Before we conclude though, I'd like to bring our focus to the third area of our discussion: Community partnerships. So, Amy, what are some of the ways that programs can take full advantage of the resources in their community and create an environment of support that can offset some of the risk factors that families might face?

Amy: Thanks, Terra. I think one of the most critical pieces, in some ways, of the Early Head Start services is connecting with other community services. So, while Early Head Start is a comprehensive program, we can't do it all and we really need to rely on the other agencies and the other services in the community. So, it's really about finding out who's in your community? What are the services? What do they offer? And then building those relationships that goes back to that sort of intentionality again of, so when you make a referral, when you get the "yes" to the questions that you're asking; you can make a referral that's personal to the issue at hand, but also to an individual person so that, you know, you're not just giving someone a 1-800 number or saying, "oh, call this agency," but you can actually say, "I know someone at this agency and they are terrific and may I introduce you to them?" "Can we call them together or can I, you know, make an appointment and would you like me to go with you?" I mean, very personalized relationships, I think, is what makes the difference between someone following up on a referral versus, it just getting dropped. Or, you know, families, like all of us, right, are very unsure of taking the next step sometimes or are not entirely sure that they're ready for change. And the more we can do to make that process easy and comfortable, I think the better off...the more likely that that referral will be effective.

Cleo: Right. And I think you're...you're right in terms of...I think that we as programs and as of agencies have to be constantly identifying who are those partners? Who are those potential partners in our community? Because you're right. And they change, and personnel change. And so we have to be constantly...I like to say, you know, we have to identify who these partners are and then we have to you know, relate and build a relationship with them. And then we have to nurture that relationship

I think too, because, you know, so that we have comfort and then we have confidence, too, when we send a family over to ABC organization, that we know they're going to be well cared for and that they're going to be respected and that they're going to be, that their needs are going to be met, and they're going... it's going to be done in a responsive way. So, and that's through nurturing that relationship and then I think we always have to be evaluating the relationship too. It's like: Is this an effective relationship? Is this working for us as an organization? Is this working for our families? And so I think it's a constantly, moving, or it's just continuous.

Amy: It requires ongoing effort. And, you know, I mean, one of the issues I think, is that we...to get at that, whether this is an effective service, is we need to be following up with families I mean, and it's right in the Standards, but sometimes, you know, it's forgotten, in terms of, you know: How did this service work for you? Was this effective? Was this what you imagined it would be when you went? And through asking those follow-up questions with families, you know, did you call? What was it like? Exactly. Exactly. Then, we can begin to evaluate how the services are.

Cleo: Right. Right. Exactly. And then, you know, and maybe when we do create some of the relationships that we have to evaluate, and then say: You know what? I think that there's another organization that may be better suited for the family's needs that we have. So, I think it's...it's fair to evaluate those relationships within your community.

Amy: Absolutely. And one way I think to cultivate and maintain and evaluate the relationships in the community is also to invite some of those community agencies on to your health services advisory. And so, I've even heard some really creative things, like, programs having a mental health services advisory, you know, separate, when they were dealing with a lot of mental health concerns and they really needed to cultivate, relationships with mental health agencies that previously had not gone so well. And so, by having a separate mental health services advisory, they were able to meet each other and understand what each other's needs were and requirements in the program, and really be able to, with the families' permissions, of course, coordinate care.

Terra: Right. And I was just going to say, to have a sense of that joined community effort around a particular issue. You mentioned mental health and it made me think of some discussions we've had about, traumatic experiences like Hurricane Sandy or things like that where a community really has to mobilize. And certainly, the Early Head Start program and many communities like, on the East Coast had to a lot of ways be central to some of those efforts around supporting the children and the families in the community.

Cleo: Absolutely. And again, I...and when I think about, you know, relationships and community partnerships and I think it has to be give and take too. Like we can't always expect our community partners to give to us. We need to be willing to also provide for them as well. And so I think that we oftentimes think all relationships we take, take, take. No, it's a give and take and, it's like, how do we support each other? And, so, you know, I think that that's important to keep in mind.

Amy: Absolutely.

Terra: Wow. You've both have given programs so much to think about. We're almost out of time, but before we end I'd like to review a few of the key points made today. First, it's important to acknowledge that children, even the youngest infants and toddlers, are impacted by adverse experiences. Infants and toddlers are very in tune to the world around them and, particularly, to the emotional experiences of their primary caregivers. It's not the case that they're too young to absorb what's happening in the family, and we now know that early experiences of physical, psychological, and emotional trauma can have long-term damaging effects. However, through providing high quality program services, we have the capacity to mitigate these effects.

We also learned that it's important to routinely listen to and value families stories, so we gain insight into the family's history, culture, and experiences. It's also very important to acknowledge the reality of "yes" answers, to tough questions about whether families and children have encountered adverse childhood experiences, such as physical, sexual, or emotional abuse, family violence, mental illness, substance abuse, parental incarceration, or other traumatic events. Programs must provide ongoing professional development opportunities and engage in intentional program planning, so that all staff are well-trained and fully prepared to respond to families in these situations. We discussed the important fact that every single interaction with a child and family is an opportunity to build a relationship and ultimately to change that family's trajectory. Through meaningful relationships and high-quality, comprehensive services, we can support the family on their path to stability and success. And we also discussed the importance of using the existing systems in the community and working with partners to develop new systems for primary prevention that create a seamless system of support.

As we conclude today's discussion, I want to thank Cleo and Amy for being here with me in the studio. I also want to thank all of you for joining us for this discussion, and to remind you that the live audio call, question and answer session with Dr. Felitti, is about to begin. I hope you have your questions ready. If you have a question for Dr. Felitti, you can access the call internationally by dialing 719-325-2176. In the United States; you can call toll free at 800-967-7149. For both numbers, the participant passcode is 471645. The audio for the question and answer session will be broadcast right here, so, if you don't have a question yourself, but want to hear what others have to say, you can simply stay right here and listen in. Take care and don't forget about the two Track C webinars airing later this week. I hope you enjoy the remainder of our Virtual Birth To Three.

[Music]

Terra: Good afternoon and welcome to the virtual Birth to Three Institute live question and answer session with Dr. Felitti for his presentation, "Adverse Childhood Experiences: Early Experiences Do Matter." I'm Terra Bonds Clark and while we are waiting for our first caller, I'd like to thank Dr. Felitti for that wonderful presentation and for joining us for this live question and answer event. I'd also like to thank our panelists, Amy Hunter from the National Center on Health and also our special guest, Sarah Merrill from the Office of Head Start who is with us as well. Dr. Felitti, would you like to say a few words?

Dr. Felitti: Well I'm glad to be with you all. It will be interesting to see what questions come in from around the country.

Terra: Operator, do we have our first caller yet?

Operator: Not at this time, but, once again, it is "star one" to signal with a question over the phone please. Star one.

Terra: Thank you. Dr. Felitti, while we are waiting for our first caller, I'd like to ask you: Head Start and Early Head Start programs provide comprehensive services to children and their families, which include health, nutrition, social services, and other services as well. And based on what you've learned from your research, can you discuss some strategies for primary prevention practices that can support Early Head Start programs and personnel as they work with families and children?

Dr. Felitti: Well, yeah. This is a big issue in terms of primary prevention and the reason it's a big issue is because the prevalence of the problem is so enormous that to attempt to deal with it by repair after the fact is really not a workable approach for the entire population. I mean, it's a wonderful thing for the small numbers of people who might benefit from such an approach and who do benefit from such an approach. But the reality is that the numbers are so great, that if anything meaningful is to be done on a population basis, it really has to be done in terms of primary prevention. That is to say, figuring out what to do to prevent the occurrence of the problems, in the first place, rather than deal with them afterwards. To that end, it seems fairly clear to those of us that have been involved in the ACE study, that the essential approach would need to center on figuring out how to improve parenting skills across

the nation. And then the question comes: "Well, how would one do that?" You know, obviously one could do it ...it sounds like the first phone call. We can pick this up again, if that's the case.

Terra: Well, in the meantime, Dr. Felitti, I really appreciate what you were just saying and I wonder if either Amy or Sarah, would you like to add to what Dr. Felitti was just sharing?

Dr. Felitti: Oh well, I only began. I haven't hit the main part of the idea yet. Namely, how would one approach this with, you know, huge populations of people, millions of people? To do that on an individual basis is not realistic. I mean, working on an individual basis is enormously important and tremendously beneficial for the people who are the recipients of that. But it doesn't address the bulk of the population, the bulk of the problem in the population. To do that, you really need an approach that would reach out to millions or tens of millions of people. The low hanging fruit there, it seems to me, would be that huge piece of the population who has had no skills, no...sorry, no personal experience with supportive parenting themselves.

And the question is: "If they only knew what supportive parenting looked like, might some meaningful portion of them do a great deal better if and when they had children? And the question...if one understands the logic of that, then, the question comes: "Well, how does one reach out, literally, to millions of people?" The two vehicles would, of necessity, be either broadcast television or Internet. And the next question becomes: "Well, does one attempt to transfer the information didactically?" You know, lessons: "I'm going to teach you how to do this." Or does one attempt to do it more subtly, in a way that's less open to rejection, in which case weaving it into a storyline becomes a highly likely option. So, one idea that has come up, repeatedly, is could one develop a serial television program, a soap opera, if you will, that would have built into it illustrations of what supportive parenting looked like and how it played out over time, contrasting that with illustrations of what destructive parenting looks like and how it plays out over time.

Terra: Okay, great. Well, Dr. Felitti, I wanted to see if Sarah Merrill, would you like to add anything to, or comment to what Dr. Felitti has just shared?

Sarah: I think those are wonderful strategies and something that the nation needs to think about. And, you know, I think for programs who are working in their local areas might be wondering how to do that in their local areas. And I think through what we heard Cleo and Amy talking about, supporting their direct service staff and addressing those families who are the most at risk, would be a great step until we can get the macro piece going. I love the idea of thinking about the Internet and the broadcast TV and there might be some examples that our families can think of who illustrate positive parenting that

they would be known to. And that might be a way for staff and home visitors to perhaps create a positive storyline on how our families might want to turn their parenting into a proactive, impactful way for themselves as parents for their teachers.

Dr. Felitta: One thing that could be done locally would be anyone who is a Ph.D. candidate in a relevant field might find the development of a pilot for such a program a meaningful thesis project. And if that were done successfully, not only would that be a tremendous public service, but one might expect that the person doing that successfully might become wealthy, in addition.

Terra: And I think, uniquely, also, Dr. Felitti, where the macro perspective that you present, as an idea of where we might engage the masses, I think what Early Head Start and Head Start program has been doing at a local level on a day-to-day basis with families is certainly an opportunity to work with maybe smaller numbers of families that are participating in the program. And I think Early Head Start is in a unique position to...even if it's one family at a time, as we're serving many families in our communities...to be able to have those conversations and to impact the way that parents think about parenting as well as their child's development and certainly the positive experiences that they're providing to their children. Amy, did you want to add something to that?

Amy: Well, you know, again, I probably will echo what Sarah was saying and what Dr. Felitti was saying about those are great strategies for the large scale. And, you know, the problem is, though...or the problems are so pervasive that we do want to look at sort of the large-scale solutions that might be able to touch, you know, millions of families. And, you know, in each local Early Head Start program, you know, the one-on-one interactions, while they aren't reaching the millions, are certainly impactful for the individual family that is developing that trusting and respectful relationship with the staff. And for that individual family, that relationship and that service that Early Head Start is providing is going to be incredibly, you know, even life-changing for them.

Dr. Felitti: There is no question about that. And, in addition, what one learns from those is essential for providing a knowledge base for figuring out what to do on a large scale, on a macro scale.

Terra: Absolutely. Operator, do we have any questions from the audience?

Operator: Not at this time, but I would like to remind them to please press "star one," if you would like to signal with a question. Again that is "star one."

Dr. Felitti: Well, the lack of response is an interesting insight. I mean, this is a subject...the ACE study has been a subject that has attracted intense, intellectual interest throughout the United States, Canada, and Northern Europe, but no engagement in terms of clinical practice. That's been a surprise. And it's an important issue and the question is: "Why?"

Terra: We had...yes, Go ahead, Dr. Felitti. Dr. Felitti: We had an interesting experience in the department that I ran, where at an early point it was obvious that we needed to take what we were learning from the ACE study and integrate into everyday medical practice. And so we introduced it into an already quite lengthy medical questionnaire that people had to fill out ahead of time at home before they came in for comprehensive medical evaluation. This was adults, typically, middle-aged or older adults.

And after we did this for a couple of years and everything was going smoothly, an outside data mining company came and did a study of 125,000 adults who went through the program with the trauma-oriented questions buried in the comprehensive medical questionnaire that they filled out at home. To our absolute amazement and pleasure, we found that this change was associated with a 35 percent reduction in doctor office visits in the year subsequent, and an 11 percent reduction in emergency department visits. So, the benefits of doing this are really profound. On the other hand, many people then ask me: "Oh, that must have spread like wildfire through big organizations like Kaiser Permanente." No, not at all. Most physicians are far more comfortable practicing biomedicine than biopsychosocial medicine. And so one sees interest in what we learned in the ACE study, but great resistance to putting it into one's own personal practice.

Terra: Absolutely. Sarah, did you want to add something to that?

Sarah: Well, I don't have a solution for you but I was watching the webcast before I jumped on the phone for the call. I remember thinking that I'm glad there was a panel discussion afterwards to help unpack all the messages you gave, because they are very poignant and very deep and there is a wondering of: "What do I do with this information?" And I imagine that translates down to the staff on the field who are interacting on a daily basis with the children and families. And they know that their work is very important and this adds a whole another layer of value and effort, but how do I make this come into practice? So, I love that Amy and Cleo are able to help unpack that a little bit further through their panel discussion and that through the webinars this week, there might even be a few other strategies to help staff and managers who support their staff in asking these questions which, as you've said, can be sometimes taught. We don't want to ask these questions, they can seem a little prying, but they have great benefit.

Dr. Felitti: That raises the issue of how one asks them. And the two choices obviously are verbally, interpersonally, or by questionnaire. And we've found the use of a well devised questionnaire to be enormously advantageous. There're all sorts of problems doing this the first time face-to-face, you know, with a stranger.

Terra: Absolutely.

Dr. Felitti: There's the issue of time, because this is really quite time consuming. There's the issue of making a legible record out of it. But then, even more, there are all sorts of interpersonal issues. Well, you know, this person that's asking me is kind of too young, they're not going to understand, or too old, you know, they're not going to understand. Or I'd rather talk with a woman or a man or, you know, someone who is Asian like me. They'll understand me better, etcetera. What we saw with a well devised, paper-based questionnaire, in our experience, was that people tend unconsciously to attribute to that device the characteristics they would want in their ideal interviewer. That was really a very, very interesting thing to see. You know, plus it gave us the advantage of not occupying any time of providing us, you know, complete legibility throughout a legible record, etcetera. And one of the things that we're working on now, or that I'm working on now, is the development of a really comprehensive medical questionnaire to be placed on the Internet so that it will have biomedical, psychological, social, family, developmental, occupational, environmental, and, in particular, trauma-oriented components that anyone who wishes could fill that out at home, thereby escaping the well intentioned but nuisance HIPAA regulations. And if they wish, print it out and give it to their physicians, most of whom will not be grateful for the information because they will realize that its mere possession imposes a responsibility on them.

Terra: Dr. Felitti, one thing that I know that Amy and Cleo both talked about in the panel discussion was what you're discussing now about Early Head Start and Head Start staff being not only, one, willing to ask those questions, those very tough questions, but also being prepared if the families that we're working with have "yes" answers. What are the resources that we as programs have available to support parents and parenting, as well as, in working with their children, and how do we support them when they do acknowledge that they've had some of these experiences in having program supports in place that will be able to offer the assistance to families that they need? Amy, would you like to...oh, go ahead, Dr. Felitti.

Dr. Felitti: What would be really useful would be to figure out how to share that with other people who don't have that experience. To show them...not tell them, to show them...that it can be done. And the question that jumps to my mind is: "Well, how might one videotape that to use excerpts for teaching purposes?" I have been amazed at how cooperative patients are. I mean, many people with, you know,

really hideous childhood histories, I'll tell them: "Look, you know things the doctors need to know. Would you be willing to talk with me on videotape, so that we can use this to help other people understand more about these problems?" I have never been turned down. And the interesting thing is the closing line, almost always, is, "Yeah, if you think it would help somebody doctor, okay I'll do that." The idea of being able to help other people is a tremendously powerful tool to getting agreement. So, you have a resource that you really ought to think about developing further to show others, home visitors, physicians, etcetera, what this kind of conversation successfully done looks like.

Amy: I think that's a great idea.

Terra: So, Dr. Felitti, we are out of time, unfortunately, and I really appreciated the insights that you have shared with us. And I also want to thank Sarah Merrill for joining us as well as Amy Hunter. And I'd also like to thank all of you who participated in the webcast today and remind you that Tuesday we have another webinar on "Using Motivational Interviewing Strategies and Principles," and on Thursday a webinar on "Partnering with Families Who Are Coping with Adversity." So, please join us on Tuesday and Thursday for more virtual Birth to Three. And we thank you all for your participation. Have a wonderful afternoon.