



POLICY STATEMENT

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

abstract

FREE

Advances in a wide range of biological, behavioral, and social sciences are expanding our understanding of how early environmental influences (the ecology) and genetic predispositions (the biologic program) affect learning capacities, adaptive behaviors, lifelong physical and mental health, and adult productivity. A supporting technical report from the American Academy of Pediatrics (AAP) presents an integrated ecobiodevelopmental framework to assist in translating these dramatic advances in developmental science into improved health across the life span. Pediatricians are now armed with new information about the adverse effects of toxic stress on brain development, as well as a deeper understanding of the early life origins of many adult diseases. As trusted authorities in child health and development, pediatric providers must now complement the early identification of developmental concerns with a greater focus on those interventions and community investments that reduce external threats to healthy brain growth. To this end, AAP endorses a developing leadership role for the entire pediatric community—one that mobilizes the scientific expertise of both basic and clinical researchers, the family-centered care of the pediatric medical home, and the public influence of AAP and its state chapters—to catalyze fundamental change in early childhood policy and services. AAP is committed to leveraging science to inform the development of innovative strategies to reduce the precipitants of toxic stress in young children and to mitigate their negative effects on the course of development and health across the life span. *Pediatrics* 2012;129:e224–e231

INTRODUCTION

“It is easier to build strong children than to repair broken men.”

Frederick Douglass (1817–1895)

From the time of its inception as a recognized specialty of medicine, the field of pediatrics has attached great significance to both the process of child development and the social/environmental context in which it unfolds. When the American Academy of Pediatrics (AAP) was founded in 1930, the acute health care needs of children were largely infectious in nature.¹ Over the ensuing 80 years, as increasingly effective vaccines, hygiene, and other public health initiatives produced dramatic gains, astute observers began to note that many noninfectious disease entities, such as developmental, behavioral, educational, and

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, COMMITTEE ON EARLY CHILDHOOD, ADOPTION, AND DEPENDENT CARE, AND SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS

KEY WORDS

advocacy, brain development, ecobiodevelopmental framework, family pediatrics, health promotion, human capital investments, new morbidity, toxic stress, resilience

ABBREVIATIONS

AAP—American Academy of Pediatrics

EBD—ecobiodevelopmental

This document is copyrighted and is property of the American Academy of Pediatrics and its Board of Directors. All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors. The American Academy of Pediatrics has neither solicited nor accepted any commercial involvement in the development of the content of this publication.

All policy statements from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

www.pediatrics.org/cgi/doi/10.1542/peds.2011-2662

doi:10.1542/peds.2011-2662

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2012 by the American Academy of Pediatrics

family difficulties, were playing increasingly prominent roles in affecting child health and well-being.

In 1975, the term “new morbidity” was introduced to describe those non-infectious entities that appeared to be most prevalent.² This important conceptualization underscored a growing realization that significant societal changes (eg, increasing numbers of single parents and families with 2 working parents) were challenging pediatric health care providers to address complex concerns that were not strictly medical in nature. Although the impact of these “new” morbidities on pediatrics, public health, and society in general is no longer in question,^{3–5} the professional training and practice of pediatricians continues to focus primarily on the acute medical needs of individual children. The pressing question now confronting contemporary pediatrics is how we can have a greater impact on improving the life prospects of children and families who face these increasingly complex and persistent threats to healthy development.

The need for creative, new strategies to confront these morbidities in a more effective way is essential to improve the physical and mental health of children, as well as the social and economic well-being of the nation.⁶ Developmental, behavioral, educational, and family problems in childhood can have both lifelong and intergenerational effects.^{7–18} Identifying and addressing these concerns early in life are essential for a healthier population and a more productive workforce.^{5,6,19–21} Because the early roots or distal precipitants of problems in both learning and health typically lie beyond the walls of the medical office or hospital setting, the boundaries of pediatric concern must move beyond the acute medical care of children and expand into the

larger ecology of the community, state, and society. Because this call for a broader, contextual approach to health is not new,²² and the track record of matching rhetoric with effective action is limited, there is a compelling need for bold, new thinking to translate advances in developmental science into more effective interventions.

THE MERITS OF AN ECOBIODEVELOPMENTAL FRAMEWORK

The accompanying technical report²³ presents an ecobiodevelopmental (EBD) framework for understanding the promotion of health and prevention of disease across the life span that builds on advances in neuroscience, molecular biology, genomics, and the social sciences. Together, these diverse fields provide a remarkably convergent perspective on the inextricable interactions among the personal experiences (eg, family and social relationships), environmental influences (eg, exposures to toxic chemicals and inappropriate electronic media), and genetic predispositions that affect learning, behavior, and health across the life span. Applying this EBD framework to the challenges posed by significant childhood adversity reveals the powerful role that toxic stress can play in disrupting the architecture of the developing brain, thereby influencing behavioral, educational, economic, and health outcomes decades and generations later.²⁴ In contrast to positive or tolerable stress, toxic stress is defined as the excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships.²⁵ Within the ongoing interplay among assets for health and risks for illness, toxic stress early in life plays a critical role by disrupting brain circuitry and

other important regulatory systems in ways that continue to influence physiology, behavior, and health decades later.²⁵ In short, an EBD approach to childhood adversity suggests that (1) early experiences with significant stress are critical, because they can undermine the development of those adaptive capacities and coping skills needed to deal with later challenges; (2) the roots of unhealthy lifestyles, maladaptive coping patterns, and fragmented social networks are often found in behavioral and physiologic responses to significant adversity that emerge in early childhood; and (3) the prevention of long-term, adverse consequences is best achieved by the buffering protection afforded by stable, responsive relationships that help children develop a sense of safety, thereby facilitating the restoration of their stress response systems to baseline.²⁵ An EBD approach recognizes that it is not adversity alone that predicts poor outcomes. It is the absence or insufficiency of protective relationships that reinforce healthy adaptations to stress, which, in the presence of significant adversity, leads to disruptive physiologic responses (ie, toxic stress) that produce “biological memories”²⁶ that increase the risk of health-threatening behaviors and frank disease later in life. The recent AAP technical report²³ summarizes the growing evidence base that links childhood toxic stress to the subsequent development of unhealthy lifestyles (eg, substance abuse, poor eating and exercise habits), persistent socioeconomic inequalities (eg, school failure and financial hardship), and poor health (eg, diabetes and cardiovascular disease). Given the extent to which costly health disparities in adults are rooted in these same unhealthy lifestyles and persistent inequalities,^{5,9} the reduction of toxic stress in young children ought to be

a high priority for medicine as a whole and for pediatrics in particular.

AN IMPORTANT ROLE FOR THE PEDIATRIC MEDICAL HOME

The effective reduction of toxic stress in young children could be advanced considerably by a broad-based, multisector commitment in which the profession of pediatrics plays an important role in designing, implementing, evaluating, refining, and advocating for a new generation of protective interventions. Pediatric providers are uniquely qualified and placed to assist in translating recent advances in developmental science into effective interventions for the home, the clinic, and the community. In addition to regular interactions with young children and an appreciation for the important role that families^{27–29} and communities³⁰ play in determining child well-being, pediatricians bring several time-honored perspectives to this challenging task. These perspectives include a developmental approach to health, an understanding of the advantages of prevention over remediation, and an awareness of the critical importance of effective advocacy to promote changes in well-established systems that influence child health and development, even when those systems lie outside the traditional realm of pediatric practice.³¹ In this context, it is essential that innovative and practical strategies continue to be developed that strengthen the capacity of the medical home to reduce sources of toxic stress and to mitigate their impact on the lives of young children. Rather than continuing the current trend of “doing more with less,” as pediatricians take on a wide range of additional responsibilities, payment reforms should reflect the value of pediatricians’ time and knowledge,

as well as the importance of a pediatrician-led medical home serving as a focal point for the reduction of toxic stress and for the support of child and family resiliency. This additional work and the reprioritization of efforts should reflect pediatricians’ interest in preventive care that is more developmentally relevant,³² parents’ desire for a greater emphasis on their child’s emerging skills and behavior,³³ the commitment to team-based services within the pediatric medical home,²⁸ and the growing evidence base that early developmental interventions can have significant effects on life-course trajectories.³⁴

As the most logical candidate for a universal platform to promote healthy development and optimal life course trajectories, the pediatric medical home has become the focus of both increasing expectations and formidable challenges. High expectations are grounded in the public’s deep respect for pediatricians as trusted guardians of child health. Compelling challenges include (1) the need for more extensive training for all health professionals on the adverse effects of excessive stress on the developing brain, as well as on the cardiovascular, immune, and metabolic regulatory systems (the technical report²³ is a start); (2) the significant constraints on existing, office-based approaches to fully address the new morbidities effectively; (3) the relatively limited availability of evidence-based strategies, within the medical home and across the full array of existing early childhood service systems, that have been shown to reduce sources of toxic stress in the lives of young children or mitigate their adverse consequences³⁵; and (4) the financial difficulties associated with the incorporation of evidence-based developmental strategies into the pediatric medical home.

A Critical Assessment of Prevention at the Practice Level

From immunizations to seat belts to parenting education, the field of pediatrics has always embraced the centrality of prevention. That said, some degree of childhood adversity is inevitable, and dealing with manageable levels of stress is an important part of healthy development. Because the essence of toxic stress is the absence of buffers needed to return the physiologic stress response to baseline, the primary prevention of its adverse consequences includes those aspects of routine anticipatory guidance that strengthen a family’s social supports, encourage a parent’s adoption of positive parenting techniques, and facilitate a child’s emerging social, emotional, and language skills. Examples include the promotion of the 7Cs of resilience (competence, confidence, connectedness, character, contribution, coping, and control),³⁶ optimism,³⁷ Reach Out and Read,^{38–40} emotional coaching,^{41–44} and numerous positive parenting programs (eg, Triple P,^{45–47} Incredible Years,⁴⁸ Home visiting,^{49,50} and Nurturing Parenting^{51,52}). Although AAP resources, such as *Bright Futures*,⁵³ *Connected Kids*,⁵⁴ and the clinical report “The Pediatrician’s Role in Child Maltreatment Prevention,”⁵⁵ already provide significant recommendations in this area, implementing a comprehensive, yet practical program of effective anticipatory guidance that nurtures the child’s emerging social, emotional, and language skills and promotes positive parenting remains an ongoing challenge.

Beyond working to improve the impact of anticipatory guidance provided in the medical home, some motivated pediatric providers also advocate for a variety of community-based interventions that are implemented in homes,^{56,57} preschools,⁵⁸ and

schools,^{59–61} as well as through an extended array of programs organized by faith-based organizations, social groups, and recreational centers. A more thorough description of the full range of practices designed to strengthen parenting skills and enhance child development can be found elsewhere.^{35,62–64} Although most primary prevention programs have not been evaluated systematically, those that show promise should be assessed and, if found to be effective, replicated and taken to scale. As the number of evidence-based services increases, the pediatric community needs to continue to advocate for systemic changes in reimbursement strategies that incentivize collaboration among pediatric medical homes and the full range of effective community-based resources.⁶⁵

Screening for Children and Families at Risk

Identifying children at high risk for toxic stress is the first step in providing targeted support for their parents and other caregivers. The challenges of developing secondary prevention strategies within the medical home begin with the implementation of practice-relevant screening and proceed through the complexities of diagnostic evaluations, sharing information, formulating joint action plans with parents, locating needed services beyond the medical home, arranging successful referrals, and conducting an ongoing monitoring and assessment of intervention impacts. That said, after several decades of prescriptive guidelines and outcome evaluations of a broad array of prevention strategies, the cumulative evidence of effectiveness is mixed. Some primary care practices have been successful in regularizing the identification and management of new morbidities within their daily routines.

Many continue to struggle with the basics of developmental screening, routine referral, and ongoing collaboration with community-based programs outside the medical system.³² All confront the limited availability of accessible and affordable preventive supports for children and families experiencing significant adversity.

Within this highly variable and multi-dimensional context, the AAP and others have encouraged pediatric providers to develop a screening schedule that uses age-appropriate, standardized tools to identify risk factors that are highly prevalent or relevant to their particular practice setting.^{29,66,67} In addition to the currently recommended screenings at 9, 18, and 24/36 months to assess children for developmental delays, pediatric practices have been asked to consider implementing standardized measures to identify other family- or community-level factors that put children at risk for toxic stress (eg, maternal depression, parental substance abuse, domestic or community violence, food scarcity, poor social connectedness). Pediatric providers have been encouraged to use *Current Procedural Terminology* code 99420 when they are assessing a child's risk and, if additional visits are needed to address any identified concerns, providers are encouraged to bill for that additional time by using codes 99401–4.⁶⁸ Continued advocacy at the national and state levels is needed, however, to ensure proper payment for the time needed for universal screening, problem identification, and ongoing assessments. More specific recommendations (regarding which screening tools should be used, when they should be administered, and how to secure reimbursement for their use) will be presented in a forthcoming AAP policy statement on social-emotional screening.

Collaborating With the Community

Routine screening for increased vulnerability is useful only if collaborative relationships exist with local services to address the identified concerns (as outlined in several previous reports^{69–71}); moreover, it is also essential that those services demonstrate evidence of effectiveness. This is particularly important for the identification of young children experiencing toxic stress, given the limited proportion of community-based interventions for which significant, positive impacts have been documented in this domain, and the relatively modest magnitude of impact found for those that have been shown to be effective.

Rethinking Advocacy Beyond the Office Setting

Because so many of the origins and consequences of childhood toxic stress lie beyond the boundaries of the clinical setting, pediatric providers are often called on to work collaboratively with parents, social workers, teachers, coaches, civic leaders, policy makers, and other invested stakeholders to influence services that fall outside the traditional realm of clinical practice.⁷² In many cases, these efforts extend even further afield, moving into the realm of ecologically based, public health initiatives that address the precipitants of toxic stress at the community, state, and national levels. Translating advances in developmental science into effective interventions and lifelong health will require a fundamental shift in the way the general public and policy makers view and invest in early childhood. Pediatric providers are integral to this effort, as they have a long history of advocating for systemic changes to advance child health and development.⁵¹

Examples of preventive interventions that could serve as targets for pediatrician-led advocacy campaigns include (1) education efforts focused

on parents, foster parents, child care providers, and preschool teachers to increase awareness of the adverse consequences of toxic stress in early childhood for lifelong outcomes in learning, behavior, and health; (2) calls for investments in the development of creative, new strategies that can be incorporated into home-, school-, and center-based services to reduce sources of toxic stress and to strengthen the relationships that buffer children from the long-term consequences of significant adversity; (3) investments in community-based mentoring activities (eg, after-school programs, Big Brother/Big Sister, Little League, gymnastics, martial arts programs) that provide supportive relationships for vulnerable children that help them learn to cope with adversity in an adaptive manner; (4) investments in selected early-intervention programs, early-childhood mental health services, specialized family therapies, and medicolegal partnerships that have demonstrated evidence of positive impacts on vulnerable young children and families; (5) professional development programs that educate judges and other key participants in the juvenile court and foster care systems about the biology of adversity and its implications for case management, child custody, and foster care of children who have been abused or neglected; and (6) collaborative efforts with social workers, mental health providers, and other related professionals to address urgent needs as early as possible and to integrate effective services for the most vulnerable children and their families.

Treatment of Toxic Stress

Finally, the pediatric community must provide strong, proactive advocacy for more effective interventions for

children with symptomatic evidence of toxic stress. These could include (1) the formation and/or continuous strengthening of local traumatic stress networks to treat children and families experiencing significant adversity; and (2) increasing the number of accessible, affordable, and culturally competent mental health professionals who are qualified to provide evidence-based treatments, such as trauma-based cognitive behavioral therapy and parent-child interaction therapy. In addition to the paucity of appropriately trained professionals in this area of significant unmet need, inadequate or inappropriate reimbursement mechanisms often block access to services for the most vulnerable young children. In such circumstances, pediatricians can be powerful advocates for expanded insurance coverage for childhood mental health services, even when they do not provide those services themselves.⁷³

REAFFIRMING A COMMITMENT TO LEAD

This Policy Statement builds on numerous previous statements, including those regarding the new morbidities,³ community pediatrics,³⁰ family-centered care,²⁷ home visitation,⁴⁹ and the prevention of child abuse.⁵⁵ The proposed EBD framework (1) incorporates growing evidence of the impact of toxic stress on the developing brain, (2) informs a deeper understanding of the early life origins of both educational failure and adult disease, and (3) underscores the need for collaborative efforts to prevent the long-term consequences of early adversity. The AAP is committed to leading an invigorated, science-based effort at transforming the way our society invests in the development of all children, particularly those who face significant adversity.⁷⁴

RECOMMENDATIONS

1. All health care professionals should adopt the proposed EBD framework as a means of understanding the social, behavioral, and economic determinants of lifelong disparities in physical and mental health (see technical report²³). Psychosocial problems and the new morbidities should no longer be viewed as categorically different from the causes and consequences of other biologically based health impairments.
2. The growing scientific knowledge base that links childhood toxic stress with disruptions of the developing nervous, cardiovascular, immune, and metabolic systems, and the evidence that these disruptions can lead to lifelong impairments in learning, behavior, and both physical and mental health, should be fully incorporated into the training of all current and future physicians (see technical report²³).
3. Pediatricians should adopt a more proactive leadership role in educating parents, child care providers, teachers, policy makers, civic leaders, and the general public about the long-term consequences of toxic stress and the potential benefits of preventing or reducing sources of significant adversity in early childhood. Protecting young children from adversity is a promising, science-based strategy to address many of the most persistent and costly problems facing contemporary society, including limited educational achievement, diminished economic productivity, criminality, and disparities in health.
4. Pediatricians should be vocal advocates for the development and implementation of new, evidence-based interventions (regardless of the provider or venue) that reduce sources of toxic stress and/or

mitigate their adverse effects on young children, as they are likely to produce better outcomes and potentially be more cost-effective than trying to treat or remediate the numerous consequences of excessive childhood stress that reach far into adulthood. Such advocacy is particularly important when budget constraints force critical reassessments of public spending priorities.

- Pediatric medical homes should (1) strengthen their provision of anticipatory guidance to support children's emerging social-emotional-linguistic skills and to encourage the adoption of positive parenting techniques; (2) actively screen for precipitants of toxic stress that are common in their particular practices; (3) develop, help secure funding, and participate in innovative service-delivery adaptations that expand the ability of the medical home to support children at risk; and (4) identify (or advocate for the development of) local resources that address those risks for toxic stress that are prevalent in their communities.

LEAD AUTHORS

Andrew S. Garner, MD, PhD
Jack P. Shonkoff, MD

COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, 2010–2011

Benjamin S. Siegel, MD, Chairperson
Mary I. Dobbins, MD
Marian F. Earls, MD
Andrew S. Garner, MD, PhD
Laura McGuinn, MD
John Pascoe, MD, MPH
David L. Wood, MD

LIAISONS

Robert T. Brown, PhD
Society of Pediatric Psychology
Terry Carmichael, MSW
National Association of Social Workers
Mary Jo Kupst, PhD
Society of Pediatric Psychology
D. Richard Martini, MD
American Academy of Child and Adolescent Psychiatry
Mary Sheppard, MS, RN, PNP, BC
National Association of Pediatric Nurse Practitioners

CONSULTANT

George J. Cohen, MD

CONSULTANT AND CONTRIBUTING AUTHOR

Jack P. Shonkoff, MD

Center on the Developing Child at Harvard University

STAFF

Karen S. Smith

COMMITTEE ON EARLY CHILDHOOD, ADOPTION, AND DEPENDENT CARE, 2010–2011

Pamela C. High, MD, Chairperson
Elaine Donoghue, MD
Jill J. Fussell, MD
Mary Margaret Gleason, MD
Paula K. Jaudes, MD
Veronnie F. Jones, MD
David M. Rubin, MD
Elaine E. Schulte, MD, MPH

STAFF

Mary Crane, PhD, LSW

SECTION ON DEVELOPMENTAL AND BEHAVIORAL PEDIATRICS EXECUTIVE COMMITTEE, 2010–2011

Michelle M. Macias, MD, Chairperson
Carolyn Bridgemohan, MD
Jill Fussell, MD
Edward Goldson, MD
Laura J. McGuinn, MD
Carol Weitzman, MD
Lynn Mowbray Wegner, MD, Immediate Past Chairperson

STAFF

Linda B. Paul, MPH

REFERENCES

- Baker JP, Pearson HA. *Dedicated to the Health of All Children*. Elk Grove Village, IL: The American Academy of Pediatrics; 2005
- Haggerty RJ, Roghman RK, Pless IB. *Child Health and the Community*. New York, NY: John Wiley and Sons; 1975
- Committee on Psychosocial Aspects of Child and Family Health. American Academy of Pediatrics. The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics*. 2001; 108(5):1227–1230
- Dreyer BP. Mental health and child developmental problems: the “not-so-new morbidity”. *Acad Pediatr*. 2009;9(4):206–208
- Shonkoff JP, Boyce WT, McEwen BS. Neuroscience, molecular biology, and the childhood roots of health disparities: building a new framework for health promotion and disease prevention. *JAMA*. 2009;301(21): 2252–2259
- Knudsen EI, Heckman JJ, Cameron JL, Shonkoff JP. Economic, neurobiological, and behavioral perspectives on building America's future workforce. *Proc Natl Acad Sci U S A*. 2006;103(27):10155–10162
- Anda RF, Dong M, Brown DW, et al. The relationship of adverse childhood experiences to a history of premature death of family members. *BMC Public Health*. 2009;9:106
- Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *Eur Arch Psychiatry Clin Neurosci*. 2006;256(3):174–186
- Braveman P, Barclay C. Health disparities beginning in childhood: a life-course perspective. *Pediatrics*. 2009;124(Suppl 3): S163–S175
- Chapman DP, Whitfield CL, Felitti VJ, Dube SR, Edwards VJ, Anda RF. Adverse childhood experiences and the risk of depressive disorders in adulthood. *J Affect Disord*. 2004;82 (2):217–225
- Costello EJ, Compton SN, Keeler G, Angold A. Relationships between poverty and psychopathology: a natural experiment. *JAMA*. 2003;290(15):2023–2029
- Danese A, Pariante CM, Caspi A, Taylor A, Poulton R. Childhood maltreatment predicts adult inflammation in a life-course study. *Proc Natl Acad Sci U S A*. 2007;104 (4):1319–1324
- Dietz PM, Spitz AM, Anda RF, et al. Unintended pregnancy among adult women exposed to abuse or household dysfunction

- during their childhood. *JAMA*. 1999;282(14):1359–1364
14. Dong M, Giles WH, Felitti VJ, et al. Insights into causal pathways for ischemic heart disease: adverse childhood experiences study. *Circulation*. 2004;110(13):1761–1766
 15. Dube SR, Anda RF, Felitti VJ, Chapman DP, Williamson DF, Giles WH. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: findings from the Adverse Childhood Experiences Study. *JAMA*. 2001;286(24):3089–3096
 16. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–258
 17. Kahn RS, Brandt D, Whitaker RC. Combined effect of mothers' and fathers' mental health symptoms on children's behavioral and emotional well-being. *Arch Pediatr Adolesc Med*. 2004;158(8):721–729
 18. Wickrama KA, Conger RD, Lorenz FO, Jung T. Family antecedents and consequences of trajectories of depressive symptoms from adolescence to young adulthood: a life course investigation. *J Health Soc Behav*. 2008;49(4):468–483
 19. Doyle O, Harmon CP, Heckman JJ, Tremblay RE. Investing in early human development: timing and economic efficiency. *Econ Hum Biol*. 2009;7(1):1–6
 20. Heckman JJ. The economics, technology, and neuroscience of human capability formation. *Proc Natl Acad Sci U S A*. 2007;104(33):13250–13255
 21. Center on the Developing Child at Harvard University. *The Foundations of Lifelong Health are Built in Early Childhood*. Cambridge, MA: Center on the Developing Child at Harvard University; 2010. Available at www.developingchild.harvard.edu. Accessed March 8, 2011
 22. Green M, Kessel SS. Diagnosing and treating health: bright futures. *Pediatrics*. 1993;91(5):998–1000
 23. Shonkoff JP, Garner AA and the American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health. Toxic stress, brain development, and the early childhood foundations of lifelong health. *Pediatrics*. 2011, In press
 24. Shonkoff JP. Building a new bio-developmental framework to guide the future of early childhood policy. *Child Dev*. 2010;81(1):357–367
 25. National Scientific Council on the Developing Child. *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper #3*. Cambridge, MA: National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University; 2005. Available at www.developingchild.harvard.edu. Accessed March 8, 2011
 26. National Scientific Council on the Developing Child. *Early experiences can alter gene expression and affect long-term development: Working Paper #10*. Cambridge, MA: National Scientific Council on the Developing Child, Center on the Developing Child at Harvard University; 2005. Available at www.developingchild.harvard.edu. Accessed March 8, 2011
 27. Committee on Hospital Care. American Academy of Pediatrics. Family-centered care and the pediatrician's role. *Pediatrics*. 2003;112(3 Pt 1):691–697
 28. Rushton FE. *Family Support in Community Pediatrics: Confronting New Challenges*. Westport, CT: Praeger; 1998
 29. Schor EL; American Academy of Pediatrics Task Force on the Family. Family pediatrics: report of the Task Force on the Family. *Pediatrics*. 2003;111(6 Pt 2):1541–1571
 30. Rushton FE Jr; American Academy of Pediatrics Committee on Community Health Services. The pediatrician's role in community pediatrics. *Pediatrics*. 2005;115(4):1092–1094
 31. Palfrey J. *Child Health in America: Making a Difference Through Advocacy*. Baltimore, MD: Johns Hopkins University Press; 2006
 32. Tanner JL, Stein MT, Olson LM, Frintner MP, Radecki L. Reflections on well-child care practice: a national study of pediatric clinicians. *Pediatrics*. 2009;124(3):849–857
 33. Radecki L, Olson LM, Frintner MP, Tanner JL, Stein MT. What do families want from well-child care? Including parents in the rethinking discussion. *Pediatrics*. 2009;124(3):858–865
 34. Walker SP, Chang SM, Vera-Hernández M, Grantham-McGregor S. Early childhood stimulation benefits adult competence and reduces violent behavior. *Pediatrics*. 2011;127(5):849–857
 35. Regalado M, Halfon N. Primary care services promoting optimal child development from birth to age 3 years: review of the literature. *Arch Pediatr Adolesc Med*. 2001;155(12):1311–1322
 36. Ginsburg KR. *A Parent's Guide to Building Resilience in Children and Teens: Giving your child roots and wings*. Elk Grove Village, IL: The American Academy of Pediatrics; 2006
 37. Seligman MEP, Reivich K, Jaycox L, Gillham J. *The Optimistic Child: A Proven Program To Safeguard Children Against Depression and Build Lifelong Resilience*. Boston, MA: Houghton Mifflin Co.; 2007
 38. Berkule SB, Dreyer BP, Klass PE, Huberman HS, Yin HS, Mendelsohn AL. Mothers' expectations for shared reading after delivery: implications for reading activities at 6 months. *Ambul Pediatr*. 2008;8(3):169–174
 39. Duursma E, Augustyn M, Zuckerman B. Reading aloud to children: the evidence. *Arch Dis Child*. 2008;93(7):554–557
 40. Willis E, Kabler-Babbitt C, Zuckerman B. Early literacy interventions: reach out and read. *Pediatr Clin North Am*. 2007;54(3):625–642, viii [viii.]
 41. Gottman JM. *The Heart of Parenting: How to Raise an Emotionally Intelligent Child*. New York, NY: Simon and Schuster; 1997
 42. Katz LF, Gottman JM. Buffering children from marital conflict and dissolution. *J Clin Child Psychol*. 1997;26(2):157–171
 43. Katz LF, Hunter E, Klowden A. Intimate partner violence and children's reaction to peer provocation: the moderating role of emotion coaching. *J Fam Psychol*. 2008;22(4):614–621
 44. Katz LF, Windecker-Nelson B. Domestic violence, emotion coaching, and child adjustment. *J Fam Psychol*. 2006;20(1):56–67
 45. de Graaf I, Speetjens P, Smit F, de Wolff M, Tavecchio L. Effectiveness of the Triple P Positive Parenting Program on behavioral problems in children: a meta-analysis. *Behav Modif*. 2008;32(5):714–735
 46. Prinz RJ, Sanders MR, Shapiro CJ, Whitaker DJ, Lutzker JR. Population-based prevention of child maltreatment: the U.S. Triple P system population trial. *Prev Sci*. 2009;10(1):1–12
 47. Sanders MR, Markie-Dadds C, Tully LA, Bor W. The triple P-positive parenting program: a comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *J Consult Clin Psychol*. 2000;68(4):624–640
 48. Webster-Stratton C, Mihalic SF. *The Incredible Years: Parent, Teacher and Child Training Series*. Boulder, CO: Center for the Study and Prevention of Violence, Institute of Behavioral Science, University of Colorado at Boulder; 2001
 49. Council on Community Pediatrics. The role of preschool home-visiting programs in improving children's developmental and health outcomes. *Pediatrics*. 2009;123(2):598–603
 50. Kitzman HJ, Olds DL, Cole RE, et al. Enduring effects of prenatal and infancy home visiting by nurses on children: follow-up of a randomized trial among children at age

- 12 years. *Arch Pediatr Adolesc Med.* 2010; 164(5):412–418
51. Bavolek SJ. Nurturing Parenting Program. Asheville, NC and Park City, UT: Family Development Resources. Available at: www.nurturingparenting.com/npp/index.php. Accessed March 8, 2011
 52. Woods ER, Obeidallah-Davis D, Sherry MK, et al. The parenting project for teen mothers: the impact of a nurturing curriculum on adolescent parenting skills and life hassles. *Ambul Pediatr.* 2003;3(5):240–245
 53. Hagan JF, Shaw JS, Duncan PM. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008
 54. Committee on Injury, Violence, and Poison Prevention. Policy statement—Role of the pediatrician in youth violence prevention. *Pediatrics.* 2009;124(1):393–402
 55. Flaherty EG, Stirling J Jr; American Academy of Pediatrics. Committee on Child Abuse and Neglect. Clinical report—the pediatrician's role in child maltreatment prevention. *Pediatrics.* 2010;126(4):833–841
 56. Donelan-McCall N, Eckenrode J, Olds DL. Home visiting for the prevention of child maltreatment: lessons learned during the past 20 years. *Pediatr Clin North Am.* 2009; 56(2):389–403
 57. Eckenrode J, Campa M, Luckey DW, et al. Long-term effects of prenatal and infancy nurse home visitation on the life course of youths: 19-year follow-up of a randomized trial. *Arch Pediatr Adolesc Med.* 2010;164(1):9–15
 58. Gordon M. Roots of empathy: responsive parenting, caring societies. *Keio J Med.* 2003;52(4):236–243
 59. Illinois State Board of Education. Illinois Learning Standards: Social/Emotional Learning (SEL). Available at: www.isbe.state.il.us/ils/social_emotional/standards.htm. Accessed March 8, 2011
 60. Payton J, Weissberg RP, Durlak JA, et al. *The Positive Impact of Social and Emotional Learning for Kindergarten to Eighth-Grade Students: Findings from Three Scientific Reviews.* Chicago, IL: Collaborative for Academic, Social and Emotional Learning; 2008. Available at: www.lpfch.org/sel/casel-fullreport.pdf. Accessed March 8, 2011
 61. Durlak JA, Weissberg RP, Dymnicki AB, Taylor RD, Schellinger KB. The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions. *Child Dev.* 2011;82(1):405–432
 62. Isaacs J. *Impacts of Early Childhood Programs.* Washington, DC: First Focus and the Brookings Institution; 2008
 63. Substance Abuse and Mental Health Services Administration. Promotion and Prevention in Mental Health; Strengthening Parenting and Enhancing Child Resilience. Rockville, MD: Department of Health and Human Services; 2007. DHHS Publication No. CSMH-SVP-0175
 64. Center on the Developing Child at Harvard University. *A Science-based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior and Health for Vulnerable Children.* Cambridge, MA: Center on the Developing Child at Harvard University; 2007. Available at: www.developingchild.harvard.edu. Accessed March 8, 2011
 65. American Academy of Pediatrics Council on Children with Disabilities. Care coordination in the medical home: integrating health and related systems of care for children with special health care needs. *Pediatrics.* 2005; 116(5):1238–1244
 66. Council on Children With Disabilities/Section on Developmental Behavioral Pediatrics-Bright Futures Steering Committee/Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics.* 2006;118(1):405–420
 67. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics.* 2007;120(3):547–558
 68. Earls MF; Committee on Psychosocial Aspects of Child and Family Health American Academy of Pediatrics. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics.* 2010;126(5):1032–1039
 69. Committee on Psychosocial Aspects of Child and Family Health and Task Force on Mental Health. Policy statement—The future of pediatrics: mental health competencies for pediatric primary care. *Pediatrics.* 2009;124(1):410–421
 70. Foy JM, Kelleher KJ, Laraque D; American Academy of Pediatrics Task Force on Mental Health. Enhancing pediatric mental health care: strategies for preparing a primary care practice. *Pediatrics.* 2010;125(Suppl 3): S87–S108
 71. Foy JM, Perrin J; American Academy of Pediatrics Task Force on Mental Health. Enhancing pediatric mental health care: strategies for preparing a community. *Pediatrics.* 2010;125(Suppl 3):S75–S86
 72. Ochoa ER, Jr, Nash C. Community engagement and its impact on child health disparities: building blocks, examples, and resources. *Pediatrics.* 2009;124(Suppl 3):S237–S245
 73. American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics Task Force on Mental Health. Improving mental health services in primary care: reducing administrative and financial barriers to access and collaboration. *Pediatrics.* 2009;123(4):1248–1251
 74. Shonkoff J. Protecting brains, not simply stimulating minds. *Science.* 2011;333(6045): 982–983

**Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician:
Translating Developmental Science Into Lifelong Health**

Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, Andrew S. Garner, Jack P. Shonkoff, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Andrew S. Garner, Laura McGuinn, John Pascoe and David L. Wood

Pediatrics 2012;129:e224

DOI: 10.1542/peds.2011-2662 originally published online December 26, 2011;

Updated Information & Services	including high resolution figures, can be found at: http://pediatrics.aappublications.org/content/129/1/e224
References	This article cites 54 articles, 26 of which you can access for free at: http://pediatrics.aappublications.org/content/129/1/e224#BIBL
Subspecialty Collections	This article, along with others on similar topics, appears in the following collection(s): Current Policy http://www.aappublications.org/cgi/collection/current_policy Committee on Psychosocial Aspects of Child and Family Health http://www.aappublications.org/cgi/collection/committee_on_psychosocial_aspects_of_child_and_family_health Adolescent Health/Medicine http://www.aappublications.org/cgi/collection/adolescent_health:medicine_sub
Permissions & Licensing	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: http://www.aappublications.org/site/misc/Permissions.xhtml
Reprints	Information about ordering reprints can be found online: http://www.aappublications.org/site/misc/reprints.xhtml

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Early Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science Into Lifelong Health

Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics, Andrew S. Garner, Jack P. Shonkoff, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Andrew S. Garner, Laura McGuinn, John Pascoe and David L. Wood

Pediatrics 2012;129:e224

DOI: 10.1542/peds.2011-2662 originally published online December 26, 2011;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/129/1/e224>

Pediatrics is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. Pediatrics is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2012 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 1073-0397.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

