WELCOME!
Addressing Social Health and Early Childhood Wellness (ASHEW) Presents: “Promoting Relational Health: Implementing a Public Health Approach in Primary Care”
Recorded: Friday, July 23, 2021
11AM – 1PM CT
Addressing Social Health and Early childhood Wellness Chapter Connection Learning Collaborative

CME credit available: August 10, 2021 – August 9, 2024

Attendees: Prior to the start of the activity, please review the below information to ensure successful participation in this Activity

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Purpose of Course
This webinar will explore how experiences in childhood (both positive and adverse) are strongly associated with behaviors, health, and economic productivity decades later! You cannot define or measure adversity or stress on the basis of the events. Adversity and stress are extremely subjective. Relational Health refers to the ability to develop and sustain safe, stable and nurturing relationships (SSNRs) and environments at the following levels: Dyadic level (parent or caregiver and child interactions) Familial level (intra-familial interactions) Community level (societal interactions and “normative” behaviors) Provider level (pediatric provider and patient/family interactions)

Learning Objectives
After completing this course, you should be able to:
• Define adversity and toxic stress and describe how they elucidate “the problem.”
• Define relational health and SSNRs and describe how they elucidate “the solution.”
• Describe a 2-generational, public health approach to build relational health.
• Apply this approach to three Clinical Cases.
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<td>Andrew Garner, MD, PhD, FAAP</td>
<td>Faculty and Planner</td>
<td>No</td>
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<td>Nerissa Bauer MD, MPH</td>
<td>Faculty and Planner</td>
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<td>Hilary Haftel, MD, MHPE, FAAP</td>
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**List of Principal Faculty and Credentials**
Andrew Garner, MD, PhD, FAAP
Nerissa Bauer, MD, MPH

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Andrew Garner, MD, PhD, FAAP is a Clinical Professor of Pediatrics at Case Western Reserve University, and he has practiced primary care pediatrics with University Hospitals Medical Practices in Cleveland since 2000. Dr. Garner is an active member of the American Academy of Pediatrics (AAP), serving as the President of the Ohio Chapter and as a member of the Academy’s Leadership Workgroups on Epigenetics, Poverty, and Early Brain and Child Development. Dr. Garner is the co-author the Academy’s Policy Statement and Technical Report on Childhood Toxic Stress, and he is a co-author of an AAP-published book, *Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health*. 
Promoting Relational Health:
Implementing a Public Health Approach In Pediatric Primary Care

Andrew Garner, MD, PhD, FAAP
Clinical Professor of Pediatrics
CWRU School of Medicine

1. Be Well
   Primary Preventions

2. Stay Well
   Secondary Interventions

3. Get Well
   Tertiary Treatments
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Learning Objectives

• Define adversity and toxic stress and describe how they elucidate “the problem.”

• Define relational health and SSNRs and describe how they elucidate “the solution.”

• Describe a 2-generational, public health approach to build relational health.

• Apply this approach to three Clinical Cases.
TEN Critical Concepts

10) What happens in childhood does not stay in childhood

9) You cannot define “adversity” solely on the basis of the event itself

8) An objective measure of adversity is the body’s stress response

7) It’s not “Nature Vs Nurture,” but “Nurture Dancing with Nature”

6) Resilience is the manifestation of Skills that can be learned

5) SSNRs are the antidote to ACEs, TSRs & long-term, intractable problems

4) Promoting SSNRs will require a 2-generational perspective

3) Promoting SSNRs will require a public health approach

2) SSNRs are also the therapeutic alliances that we use to help children

1) You are already doing this work, but you may not realize it!
Critical Concept #1

Life-Course Science tell us that...

Experiences in childhood (both positive and adverse) are strongly associated with behaviors, health and economic productivity ... 

... DECADES LATER!
Linking Childhood Experiences and Adult Outcomes

PCEs
Attuned adults
Play/ROR

ACEs
Violence, Abuse, Disasters ...
Poverty, Racism, Social Isolation ...

Healthy Lifestyles
Academic Success
Economic Stability

Poor Health
Academic Failure
Economic Hardship

Slide adapted from Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health, Garner and Saul, 2018. Used with permission.
Critical Concept #2

You cannot define or measure adversity or stress on the basis of the events.

Adversity and stress are extremely subjective.
A Spectrum of Adversity

Discrete, Threatening Events

Abuse  Violence  Disasters  Bullying  Parental SA  Parental MI  Racism  Poverty  Neglect

Individuals with the Highest Risk for a Toxic Stress Response

Physiologic Stress Response

Largest Number of Individuals at Risk for a Toxic Stress Response

They all make it more difficult to form SAFE, STABLE and NURTURING RELATIONSHIPS

RELATIONAL VIOLENCE, SOCIAL ISOLATION AND LONELINESS ARE DOUBLE WHAMMIES!
Critical Concept #3

An objective measure of adversity is the body’s stress response.

But NOT all stress is “BAD” stress.
Defining Adversity or Stress

Positive Stress Response

– Brief, infrequent, mild to moderate intensity
– In response to normative childhood adversities
  • Inability of the 15 month old to express their desires
  • The 2 year old who stumbles while running
  • Beginning school or childcare
  • The big project in middle school
– Safe, Stable, Nurturing Relationships*** allow a return to baseline
  (responding to non-verbal clues, consolation, reassurance, planning assistance)
– Builds motivation, confidence and RESILIENCE IN THE FUTURE!!
– “Positive Stress” is NOT the ABSENCE of stress
Defining **Adversity** or **Stress**

**Toxic Stress Response**

- Long lasting, frequent, or strong intensity
- In response to the more extreme adversities of childhood (ACEs)
  - Physical, sexual, emotional abuse
  - Physical, emotional neglect
  - Household dysfunction
- **Insufficient social-emotional buffering** *(not enough SSNRs)*
  (Deficient levels of emotion coaching, re-processing, reassurance/support)
- Chronic exposure to the physiologic mediators of stress (cortisol, epi) leads to **potentially permanent changes** and long-term effects
  - **Molecular level** (epigenetics)
  - **Cellular level** (brain connectivity)
  - **Behavioral level** (allostasis)

The same biology also explains how RH becomes biologically embedded
Survival Mode or Relational Mode?

The PFC and Hippocampus promote reflective / adaptive behaviors, but they are inhibited by the amygdala.

The amygdala promotes impulsive / aggressive behaviors, but it is inhibited by the PFC and Hippocampus.

In the absence of SSNRs or when in "survival mode," the amygdala is "in charge," and behaviors tend to be more impulsive and aggressive.

In the presence of SSNRs or when in "relational mode," the PFC and Hippocampus are "in charge," and behaviors tend to be more reflective and adaptive.

Easier to learn new skills when in relational mode!

Slide adapted from Thinking Developmentally: Nurturing Wellness in Childhood to Promote Lifelong Health, Garner and Saul, 2018. Used with permission.
Relational Health:

Refers to the ability to develop and sustain safe, stable and nurturing relationships (SSNRs) … and environments

- Dyadic level (parent or caregiver and child interactions)
- Familial level (intra-familial interactions)
- Community level (societal interactions and “normative” behaviors)
- Provider level (pediatric provider and patient/family interactions)
SAFE — safe relationships and environments are free from all forms of violence, so there is no threat of physical harm, emotional neglect or social isolation. Children do not learn new skills well if they do not feel safe. But feeling safe helps them in times of adversity.

STABLE — stable relationships and environments are predictable over time. Children do not feel safe — or learn new skills well — when relationships and environments are unpredictable. But having predictable interactions with trusted adults helps them in times of adversity.

NURTURING — nurturing relationships and environments promote the learning of new skills that allow children to be resilient in the face of future adversity. These foundational social, emotional, language and adaptive skills are learned, so they can be modeled, taught, practiced and celebrated by the safe, stable and nurturing adults in children’s lives.

* Turn off the stress response and build skills for resilience
Critical Concept #4

Development, be it adaptive or maladaptive, is the result of an on-going but cumulative dance between the ecology and your biology.
A Few Implications:

- Need to get the ecology right!! (ACEs<PCEs; changes in practice/policy; biology advocacy)

- No artificial distinctions between physical/mental wellness (stigma; adaptation)

- Many chronic conditions (NCDs) are adult manifest diseases with origins in childhood experiences

- Grounds vague terms like adversity and resilience in the biology of stress
Critical Concept #5

RESILIENCE,
(the ability to adapt to adversity in a healthy manner)
manifests a set of SKILLS
Social-Emotional **LEARNING**

Definition of SEL per CASEL:
- The process through which children … and adults:
  - Understand and manage emotions (self awareness)
  - Set and achieve positive goals (self management)
  - Feel and show empathy for others (social awareness)
  - Establish and maintain positive relationships (relationship skills)
  - Make responsible decisions (decision making)

Because these are **SKILLS** that are **LEARNED**, they can be …
- Modeled, taught, practiced, reinforced, celebrated **By whom? SSNRs!**

Strong emotions are a **NORMAL** part of being HUMAN – they are OK!
- The challenge is to be aware, normalize, learn healthy adaptations
Strong Emotions Demand Distractions

- Tantrums
- Fighting
- Smoking
- Alcohol
- Promiscuity

Unhealthy Distractions
(behavioral allostasis)

- TV Movies
- YouTube
- Social Media
- Video Games

Wastes of Time / Escapes
(OK … if not the default)

- Play Art
- Sports
- Music
- PASSIONS!

Healthy Distractions
(evidence of resilience)

Passions help kids to channel their emotional energy into something constructive.
Critical Concept #6

SSNRRs are the antidote for toxic stress responses.
Positive Childhood Experiences and Adult Mental Health

2015 Wisconsin Behavioral Risk Factor Survey of adults, by phone, \( n = 6188 \)

Looked at 7 Positive Childhood Experiences (PCE). As a child, had they:

1) felt able to talk about their feelings
2) felt their family stood by them during difficult times
3) enjoyed participating in community traditions
4) felt a sense of belonging in high school
5) felt supported by friends
6) had at least 2 non-parents adults who took an interest in them
7) felt safe and protected by an adult in their home

Adult depression / poor mental health:

1) ever told that they have depression by a health professional
2) 14 or + days in the last month that their mental health was not good
We must promote PCEs, particularly for those already dealing with adversity.
Family Resilience and Connection Promote Flourishing

Bethell et al., 2019. Health Affairs 38:729-737
National Survey of Children’s Health, 2016-7, ages 6-17, n = 51,156, parent report

Child Flourishing Index (CFI), ranges from 0-3, “definitely true” that their child:
1) “shows interest and curiosity in learning new things” - curious
2) “works to finish tasks he or she starts” - completes
3) “stays calm and in control when faced with a challenge” - control

Family Resilience and Connection Index (FRCI), ranges from 0-6
- “When your family faces a problem, how often are you likely to:”
  1) “talk together about what to do”
  2) “work together to solve our problems”
  3) “know we have strengths to draw on”
  4) “stay hopeful even in difficult times”
    - Asked parents how well they:
  5) can “share ideas or talk about things that really matter”
  6) are “handling the day-to-day demands of raising children”
Nationally, only **40.3%** of children are “flourishing” (curious, complete tasks, are in control when faced with a challenge).

Percent flourishing, by Family Resilience & Connection

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Number of ACEs:

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<td>36.6</td>
<td>48.4</td>
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<td>16.8</td>
<td>30.6</td>
<td>40.8</td>
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<td>4 – 9</td>
<td>11.9</td>
<td>21.6</td>
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**IF WE ARE ONLY LOOKING AT ADVERSITY, WE ARE MISSING THE POINT:**

**ALL KIDS NEED RELATIONAL HEALTH TO FLOURISH**

Bethell et al., 2019. *Health Affairs* 38:729-737
HIGH adversity does NOT mean that you are “broken or “doomed!”

Kids with high adversity but high relational health may fare relatively well
LOW adversity does NOT mean that you are “well” or “in the clear!”

Adverse and Positive experiences CO-EXIST in the lives of children everyday

Kids with low adversity but low relational health may fare relatively poorly
What’s Inside the Proverbial Black Box?

**Childhood Experience**

- **PCEs**
  - Attuned adults
  - Play/ROR

- **ACEs**
  - Violence, Abuse…
  - Poverty, Racism…

**Safe, Stable and Nurturing Relationships**

- Social-Emotional Learning
- Healthy Adaptations

**Toxic Stress**

- Epigenetic Modifications
- Changes in Brain Connectivity
- Behavioral Allostasis

**Adult Outcomes**

- Healthy Lifestyles
- Academic Success
- Economic Stability

- Poor Health
- Academic Failure
- Economic Hardship

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PREVENTING CHILDHOOD TOXIC STRESS:
Partnering with Families and Communities to Promote Relational Health

With a racism, poverty, socially-isolating pandemic, TS remains relevant
  - Explains how adversity is biologically embedded → impacting life-course trajectories
  - But it is a deficits-based framework (it is what happens in the absence of SSNRs)
  - Defines “the problem” & its consequences at the molecular, cellular, behavioral levels

To move forward, we need to pivot from preventing TS towards promoting RH
  - Explains how SSNRs are biologically embedded → impacting life-course trajectories
  - Is a strengths-based framework (it is what we need to get right – SSNRs)
  - Defines “the solution” & its prerequisites at the dyadic, familial, community levels
Critical Concept #7

Promoting SSNRs will require a 2-GEN APPROACH from providers.
Promoting Relational Mode

“In order to develop normally, a child requires progressively more complex joint activity with one or more adults who have …

… an irrational emotional relationship with the child. Somebody's got to be crazy about that kid. That's number one. First, last and always.”

- Urie Bronfenbrenner
Caregivers in Survival Mode

STEP 1: Provide Social Supports, Meet Caregiver Deficiency Needs

Social Determinants of Health, Unmet Caregiver Deficiency Needs

Caregivers in Relational Mode

STEP 2: Develop Safe, Stable and Nurturing Relationships with Child

Healthy Child Attachment to the Caregivers

Child in Relational Mode

STEP 3: Promote Developmentally Appropriate Play/ROR

Foundational Social, Emotional & Language Skills

Scaffolding of New Skills

Critical Concept #8

Promoting SSNRs will require a PUBLIC HEALTH APPROACH from providers, health systems ... and their communities!
<table>
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<tr>
<th>Public Health Level</th>
<th>Types of Prevention</th>
<th>Approaches to Toxic Stress</th>
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A Public Health Approach to **Prevent** Toxic Stress ... *IS* a Public Health Approach to **Promote** Relational Health!

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<th>Types of Prevention</th>
<th>Approaches to Relational Health</th>
<th>Examples at the Provider Level</th>
<th>Examples at the Practice Level</th>
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<td>Primary</td>
<td>- <strong>Promote SSNRs</strong> by building 2-Gen relational skills</td>
<td>- <strong>Be Well</strong></td>
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<td>- <strong>Promote positive parenting</strong></td>
<td>- <strong>Build the therapeutic alliance</strong></td>
<td>- <strong>Endorse Parenting Classes</strong> (e.g., Centering Parenting/Legacy)</td>
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<td>- <strong>Encourage developmentally appropriate play / ROR / VIP</strong></td>
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<td>- <strong>Participate in ROR, VIP &amp; other programs that support the dyad</strong></td>
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HORIZONTAL INTEGRATION:
MEDICAL HOMES CANNOT DO THIS ALONE!

RELATIONAL HEALTH IS A SOCIETAL ISSUE!!
Early Relational Health is Dyadic, But It is Strongly Influenced by Many Other Relationships

We ALL have a role to play in promoting relational health!
Critical Concept #9

SSNRs are also THERAPEUTIC ALLIANCES, which are the primary tool pediatric providers use to improve the child’s context.
Parenting and Parenting Interventions: It’s Complicated

Through trusted and respectful relationships with parents and caregivers, we work to improve relational health, in order to improve the health & development of our patients.
Critical Concept #10

YOU ARE ALREADY DOING THIS!
You (or your team) are likely doing many of these already ... everyday!!

The Layering of Efforts to Promote Safe, Stable and Nurturing Relationships

Symptomatic children
- All of those below, plus:
  - Evidence-based treatments (TF-CBT, CBT)
  - Repair and rebuild SSNRs (ABC, CPP, PCIT)

Indicated Tertiary Treatments

Healthy children
- Promote the development of SSNRs by:
  - Loving the child (if not the behavior)
  - Understanding child development (and what specific behaviors mean)
  - Promoting positive but authoritative (not authoritarian) parenting styles
  - Encouraging large amounts of developmentally appropriate play (ROR, VIP)

- Proactively build the foundational skills for resilience through SSNRs that:
  - Model social capacities, emotional regulation, language skills and adaptive functioning (2 generational)
  - Nurture foundational social, emotional and language skills as they emerge developmentally
  - Identify the child's passions and healthy distractions (e.g., sports, music, art, hobbies, volunteering)
  - Provide opportunities to practice and implement these foundational skills (developmentally appropriate play, sibling rivalry, everyday disappointments)

- When adversity occurs, buffer it occurs through SSNRs that:
  - Meet a child's most basic needs in order to prevent additional adversity (safe)
  - Provide routines and predictability to decrease additional stress (stable)
  - Encourage the use of healthy distractions and adaptive behaviors (nurturing)
ANY QUESTIONS?
A Public Health Approach to Build RH

Level 1 – Universal **Preventions** that actively promote RH

Level 2 – Targeted **Interventions** that address potential barriers to RH

Level 3 – Indicated **Treatments** that repair or rebuild RH once strained
Patrick is a 9 month old infant who presents for a Well Child Care appointment with his mother, Martha, and his 7 year old sister, Sarah. When you enter the room, Patrick is sitting on the examining room table next to Martha, who is sitting up but clearly asleep. Sarah is sitting in a chair next to Patrick and is entertaining him with a rattle. As you greet them, Patrick looks at Sarah with a concerned expression and starts to whimper. When you ask Sarah to give you five, she smiles and enthusiastically slaps your outstretched hand. Patrick then seems to calm a bit.
As Martha tries to wake herself from her slumber, you ask her how she is doing. She responds flatly, “Fine.” As you complete the rest of your visit, you note that:

- Patrick is looking at Sarah more than Martha
- Patrick becomes distressed when you ask Martha to hold him in her lap for the physical exam
- Patrick is growing well, demonstrates appropriate developmental milestones, and has no bruises, abrasions or overt signs of trauma on exam
- When you ask Martha what she most likes to do with Patrick, she says “I love it when he sleeps”
Red Flags:
- poor attachment (social referencing to the primary attachment figure)
- ? maternal depression, ? sleep deprivation, ? other social determinants of health
- ? age appropriate opportunities to play
Potential Responses:

- referral to attachment based therapy (ABC, PCIT, CPP; employ common factors if not available)

- screen for other barriers to relational health (MD; basic needs like food, sleep, shelter [SDoH])

- opportunities for developmentally appropriate play (ROR, VIP, parent coaches)
Pamela is a 3 year old girl who presents for a Well Child Care visit with her father, Fred. When you enter the room, Pamela is sitting on Fred’s lap and they are reading a book together. Pamela’s mother, Mary, is a corporate lawyer and travels a great deal, so Fred has been Pamela’s primary caregiver since three months of age. Fred reports that Pamela recently started attending a preschool class at the local Montessori School, and that she is really thriving there.
The rest of your interview and physical exam reveal that Pamela is growing well, demonstrates appropriate developmental milestones, has no bruises, abrasions or overt signs of trauma, and appears to have an appropriate bond with her father. As you are about to leave the room, you ask if Fred has any other questions. His smiling face falters for a moment, so you hesitate. He answers that although Pamela does well at her school and is generally appropriate with him, she is prone to excessive tantrums with Mary.
You ask for an example, and Fred replies, “If I ask Pamela to clean up her toys and come to dinner, she usually complies. But if Mary asks her to do the same, she either ignores the request or goes ballistic!” When you ask what “ballistic” means, Fred says that Pamela will start to scream, hit, spit and throw things. When you ask how long these episodes last, Fred says “for as long as we try to discipline her.” When you ask what he means by discipline, Fred laughs and says “that’s a great question, because nothing seems to work!”
Red Flags:
- situational resilience (appropriate coping in one context, but not coping well in another context)
- strong emotional reactions ("affect regulation" +/- "impulse control")
- parents struggling with "discipline techniques"
- Biological Sensitivity to Context?
Potential Responses:
- frame tantrums as times when “emotions hijack the brain”
- refer to Ross Greene and skill building – “Kids that can do well, do. Those that do not, cannot!”
- explain a BStC – “Orchid’s rule … if we learn how to channel that energy into a constructive outlet”
- discuss positive discipline techniques (catch’em being good; collaborative problem solving)
- consider attachment based therapy for Mary and Pamela
- screen for other barriers to relational health (? maternal depression; ? maternal ACEs)
- opportunities for developmentally appropriate play (ROR, VIP, parent coaches)
Peter is an almost 7 year old boy who presents for a Well Child Care visit with his mother, Maddie. When you enter the room, Maddie is looking at her phone, and Peter is playing a video game on a tablet. After a moment or two, Maddie puts her phone away, but Peter quickly returns to his game after giving you a hearty high five. So you begin by asking mom if she has any questions or concerns, which she denies. Maddie reports that Peter has been healthy, seems to be well-liked by his peers, and loves to play almost any sport. Peter recently began first grade at a local elementary school after having an “outstanding year” of kindergarten at the same school. When you ask Maddie if the kindergarten teachers had any concerns, she replies, “not really … maybe a little hyper at times and some trouble sitting still, but he seems to pick things up quickly. The teachers have recommended that he be tested for being gifted.”
After completing most of your interview with Maddie and addressing all of her concerns, you turn to ask Peter if he likes school. But he still is immersed in his game, so Maddie politely asks him to turn off the game. When Peter angrily replies “In a minute, mom,” Maddie takes the iPAD away from him. Peter’s first response is to growl, “mom!” Then, when Maddie redirects Peter to your question about school, he begins to pout and simply says, “It’s fine.” When you ask him what he likes to do outside of school, he says “basketball, or baseball or soccer.” When you ask him what he does on a rainy day, he pauses for a long time before sheepishly saying “video games.” When you ask Maddie what he does on rainy days, she says “video games … or tormenting his 4 year old little brother.”
Red Flags:
- mom’s phone use (vs interacting with the child)
- child not listening to mom’s requests
- excessive screen time
- sibling rivalry
**Potential Responses:**
- discuss concerns about screen time being the **default escape** (vs building other skills)
- discuss need for redundancy in passions / distractions (only sports?)
- use sibling rivalry as an opportunity to discuss emotional intelligence (emotions are ok, what to do with them?)
- “stop – walk away – do something you love to do … if it is healthy!”
- ?screen for potential barriers to the relational health needed to calm / build new skills (?parental screen use)
A Public Health Approach to Build RH

Level 1 – Universal Preventions that actively promote RH

Level 2 – Targeted Interventions that address potential barriers to RH

Level 3 – Indicated Treatments that repair or rebuild RH once strained
Summary (2013):

Toxic stress defines the problem.

Toxic stress explains how many of our society’s most intractable problems (disparities in health, education and economic stability) are rooted in our shared biology but divergent experiences and opportunities.
CONCLUSION:

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

Frederick Douglass