

# Recognizing and Responding to Child and Adolescent Stress: The Critical Role of the Pediatrician

*A note from the editors:*

*This article, and the other articles in this issue of Psychiatric Annals, originally appeared in Pediatric Annals, a SLACK Incorporated publication. Although this article by Drs. Lemmon and Stafford was originally written for the pediatric community, it may help the psychiatric community to view the pediatrician as a resource in addressing mental health issues in children; to reach out to pediatricians to further collaborate on critical child stress issues within their own communities; and to help foster valuable relationships with pediatricians in providing joint care and support to children within their practices.*

Pediatricians are “committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults,” according to the mission statement of the American Academy of Pediatrics (AAP). Despite this, pediatricians are sometimes narrowly viewed as specialists who only provide assessment and treatment of “medical” problems. This view overlooks the strengths and experiences pediatricians have in providing and coordinating services to ease stress and crises in the lives of children, adolescents, and their families. In fact, for a majority of children, pediatric providers are taking responsibility for the management of psychosocial conditions that were historically managed by mental health specialists.<sup>1</sup>



© iStockphoto.com/rzusek

**Keith M. Lemmon, MD; and Elisabeth M. Stafford, MD**

The idea of pediatricians serving in the role of stress and crisis “managers” is not new. Social and behavioral issues were recognized by the early leaders in pediatrics, and the style in which they are addressed constitutes the “art of pediatric practice.”<sup>2</sup> A 2001 American Academy of Pediatrics policy statement, the “New Morbidity Revisited” added school problems (including learning disabilities and attention difficulties), mood and anxiety disorders, adolescent suicide and homicide, firearms in the home, school violence, drug and alcohol abuse, HIV and AIDS, and the effects of media on violence, obesity, and sexual activity to the list of new morbidities for pediatric oversight, originally identified in a statement from 1993.<sup>3</sup> The purpose of this article is to first elucidate attributes and experiences that pediatricians already possess for dealing with stress, crisis, and the “new morbidities.” Further, it proposes strategies that can be integrated into training programs and clinical practice to better prepare pediatricians to address childhood stress and distress. It emphasizes how the recog-

---

*Keith M. Lemmon, MD, is Major, Medical Corps, U.S. Army, and is Adolescent Medicine Fellow, San Antonio Military Pediatric Center, Texas. Elisabeth M. Stafford, MD, is Colonel, Medical Corps, U.S. Army, Brooke Army Medical Center, and Adjunct Professor of Pediatrics, University of Texas, San Antonio, Texas.*

*Address correspondence to: Keith M. Lemmon, MD, Division of Adolescent Medicine, Brooke Army Medical Center, Building 3600, 3851 Roger Brooke Drive, Fort Sam Houston, TX 78234; or email Keith.Lemmon@us.army.mil.*

*Major Lemmon and COL Stafford are American Academy of Pediatrics Friends of Children Fund Research Grant Recipients.*

*The opinions and views expressed herein are those of the authors and do not reflect the official policy or position of the Department of the Army, the Department of Defense, or the United States government.*

nition and management of stress in the primary clinical setting will help serve pediatric patients and their families.

### THE PEDIATRICIAN'S ROLE

The effects of stress in childhood and adolescence can be far reaching and cause great morbidity in the pediatric population. Excessive stress can interfere with critical caregiver/child attachments, carving the initial ruts that lead to future paths of unhealthy coping and adversely impact the developing brain. Dr. Joseph Hagan stated, “Commitment to confronting the new morbidities of psychosocial problems is intrinsic to our pediatric identity, and the systemic changes necessary to allow this new standard of care are within our reach.”<sup>4</sup>

Pediatricians are ideally positioned to identify and manage crisis for many reasons (see Sidebar 1). First, they typically know the families in their practices, and most families trust that the guidance given in the pediatric office is given in the spirit of genuine caring and advocacy for the child and family. Pediatric practitioners are in a position to assess each patient's and family's intrinsic strengths and weaknesses. They understand the importance of maintaining a functional family to allow children to achieve their maximal cognitive, physical, and emotional potential. Pediatricians are familiar with the network of community services that their patients will be accessing. As a group, they understand the importance of providing culturally appropriate care to optimize therapeutic intervention.

Many families seek guidance from pediatricians during stressful times; sometimes they seek help directly for their behavioral or social challenges, and other times to address physical or physiological manifestations of stress. Pediatricians routinely care for families around the stressful birth of children, often are the first to recognize maternal depression, and are generally the first con-

#### SIDEBAR 1.

### Pediatricians have 'Built-in' Skills

- Familiarity with the family unit
- Understanding and identifying family support
- Knowledge of community support services and referral networks
- Understanding the importance of culturally sensitive care

tact when children have been victims of physical, mental, or sexual abuse. They identify and provide mitigation strategies for adolescent risk behaviors, detect regression in developmental milestones, and assist in the comprehensive evaluation of children failing in school. Pediatricians are often the front-line support for families exposed to natural disaster, unemployment, terrorism, and even war. As the burden to detect and intervene earlier and more effectively in the arena of stress and psychosocial crisis falls more heavily on the pediatrician, it is critical to insure continually improving competence in these areas.

Many pediatricians express limited comfort treating patients with psychosocial problems.<sup>5,6</sup> However, whether it is formally acknowledged or not, pediatricians develop the skills needed to manage most mild to moderate stress and psychosocial issues in the course of typical training and the early practice years. Pediatricians, as a group, understand the interrelatedness of psychosocial, emotional, and physical health. Through training and experience, pediatricians learn that if a mother is excessively stressed or depressed, she will be less likely to provide the optimal developmental environment for her newborn baby. Pediatricians may be the only professional monitor of adolescents as they navigate an overly destructive or self-injurious independence seeking stage. Well-trained pediatricians are already attuned to the effects of stress

in a family system. The charge is to refine the pediatric skill set to mentor families more effectively and consistently in taking intentional steps to optimize coping strategies that will build resilience in the face of life's challenges. The AAP has several policy statements in place that affirm the pediatrician's commitment to addressing the psychosocial and stress issues that may occur over the course of child and adolescent development (see Sidebar 2). Additionally, other youth serving organizations, such as the Zero to Three and the American Academy of Child and Adolescent Psychiatry, support similar policies to address the impact of childhood stress proactively.

A multi-layered approach should be considered to prepare and reinforce pediatricians with the needed competencies to meet the challenge of supporting families through stress and psychosocial crises. First, residency training should continue to emphasize a comprehensive view of pediatrics, including several key areas that focus on psychological and social support. Training in ambulatory settings should continue to expand the emphasis on behavioral, developmental, and psychologic issues. More in-depth developmental, behavioral, and adolescent training during residency will better equip pediatricians to address these practice challenges. The experiences require supervision by faculty with experience in the behavioral/developmental aspects of child development.<sup>7</sup> This will lead pediatricians to become more proficient at sorting out and addressing evidence of the spectrum of stress. As a metaphor, pediatricians become very good at recognizing the difference between physically sick and well children. Over time, it is referred to as a "gestalt" or an innate sense that a pediatrician develops after taking care of a few thousand children. This same sense of whether children are experiencing "typical" or "toxic" levels<sup>8</sup> of stress is equally important for pediatricians to develop.

#### SIDEBAR 2.

### Policy Statements Addressing Issues of Stress and Crisis

Committee on Psychosocial Aspects of Child and Family Health. The New Morbidity Revisited: A Renewed Commitment to the Psychosocial Aspects of Pediatric Care. November 1, 2001.<sup>2</sup>

Ginsburg KR, and the Committee on Communications and Committee on Psychosocial Aspects of Child and Family Health. Clinical Report. The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bonds. October 9, 2006.<sup>19</sup>

Hagan JF, and the Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism. Psychosocial Implications of Disaster of Terrorism on Children: A Guide for the Pediatrician. September 1, 2005.<sup>20</sup>

Committee on Early Childhood, Adoption, and Dependent Care. The Pediatrician's Role in Family Support Programs. January 1, 2001.<sup>21</sup>

Committee on Community Health Service. The Pediatrician's Role in Community Pediatrics. April 1, 2005.<sup>22</sup>

Committee on Psychosocial Aspects of Child and Family Health. The Pediatrician and Childhood Bereavement. February 1, 2000.<sup>23</sup>

(From: [www.aap.org/policystatements](http://www.aap.org/policystatements). Accessed February 8, 2007.)

Likewise, it is important for pediatricians to become attuned to the physical manifestations of emotional stress (see Sidebar 3, page 434). Medically unexplained physical symptoms may be an important clue to emotional disorders and should signal the need for careful assessment, consideration of behavioral health referral, and intervention as appropriate within the primary care setting. A recent study found that children with medically unexplained symptoms are more likely to be considered sickly and health-impaired by parents and caretakers, to be absent from school, to show decreased academic performance, to experience emotional and behavioral difficulties, and to be frequent users of health and mental health services.<sup>4,9</sup> Pediatricians are often taught that somatization, attributing physical feelings of discomfort or pain to being a manifestation of emotional distress, should only be considered as a diagnosis of exclusion. This is a safe and conservative strategy in terms of medical liability. However, it often leads to worsening stress in families as much time, anxiety, and healthcare

resources are devoted to the search for a physical cause of illness at the expense of delay in recognition and treatment of disabling stress. Recognizing the fact that emotional distress can and does cause physical discomfort and even pain is an essential concept to grasp. It is important for pediatricians to consider this potential diagnostic possibility early in the evaluation of a child with prerequisite stresses and symptoms that don't add up, or those that are commonly associated with somatization, such as unexplained headaches, gastrointestinal distress, or limb pain. Pediatric residents are often taught to work through differential diagnoses of physical complaints to the very end, even to the most unlikely causes of physical symptoms. Deliberately improving the skills and confidence to sort out whether a patient's complaints stem primarily from a physical or emotional root cause will provide an important understanding of mind/body concepts for patients and providers alike.

Leveraging community resources more effectively is another way for pe-

SIDEBAR 3.

### Competencies to Enhance Management of Stress and Psychosocial Crisis

- Knowledge of spectrum of stress and appropriate management
- Recognition of physical manifestations of emotional distress
- Learning how to apply integrated systems of care to optimize child health
- Advocacy skill development
- Developing skills in emotionally intelligent leadership

diatricians to assist distressed patients. Clearly, because the roots of children's emotional problems are multifactorial,<sup>10</sup> prevention and treatment of childhood mental health problems must involve the multidisciplinary efforts of medical, mental health, social service, and education professionals, as well as insurers. Pediatricians can also strive to be more fully incorporated into the systems of care model that envisions all professionals who provide human services as integrated and interrelated. In fact, a major barrier to asking patients about psychosocial issues may be worrying about what to do with the answers. Therefore, a first step is to be aware of community-based resources and to develop the connections with intake coordinators to those services that facilitate patients' access.

Pediatricians helping families deal with stress find themselves in positions of being advocates. Families under stress are often perceived as being unable or unwilling to speak for themselves. Environments or circumstances of poverty, trauma, poor communication, or natural disaster often create additional psychosocial challenges that add to the issues pediatricians are working to mitigate. In their capacity as a credible and authoritative voice within the community, pediatricians are often asked to identify

and address the root causes of childhood distress. To accomplish this important goal, competent communication and advocacy skills are needed. It is possible to facilitate advocacy skills development in pediatric training programs, but such skill development must be proactively built into the curriculum and training structure. Effective leadership training that accentuates the concept of emotional intelligence is also an essential pediatric skill. Leadership is the ability to provide purpose, direction, and motivation to those who follow. Emotional intelligence refers to an ability to recognize the meanings of emotion and their relationships, and to reason and problem-solve on the basis of them. It is the capacity to perceive emotions, assimilate emotion-related feelings, understand information of those emotions, and manage them.<sup>11</sup> Emotionally intelligent leadership is typically thought of as a skill to be developed in the later stages of a pediatric career. However, it is helpful to conceptualize even young pediatricians as advocates for children and families and as community leaders. Emotionally intelligent leadership can be an effective tool in helping families and one that all pediatricians should be ready to use at a moment's notice.

#### MANIFESTATIONS OF STRESS IN THE CLINICAL SETTING

Stress and psychosocial challenges present in many forms in the pediatric office. All families encounter stress, but increased vulnerability is present in some subpopulations; including children with special needs or chronic illness, families living below the poverty level, parents with a chronic or recurrent physical or mental illness, immigrant families, and families exposed to the insecurities of natural disaster. Another population that has emerged as a particularly stressed population over the past 5 years is the American military family, and it is timely to draw particular focus to this group

in the context of childhood stress assessment. Because National Guard and Reserve military forces are increasingly utilized for wartime deployments, children exposed to the stress of being in a military family expands outside the gates of military bases to nonmilitary pediatric care providers. Reserve component service members have been called up and participate in all of the activities and stresses traditionally experienced by active duty military forces. These families are being cared for in civilian pediatric and primary care practices across the country. Unique stresses occurring in these families may not be receiving full attention in civilian practices because of a lack of knowledge of the specific needs of those in military families.

The American military family is an excellent model in which to examine the spectrum of stress. When not at war, military families are exposed to mild levels of stress through frequent moves, which cause temporary family disorganization and may prevent the establishment of deeply rooted support systems. Children's behavioral responses and mental health status during non-combat or routine moves or deployments often correlate to the level of concurrent family stressors.<sup>12</sup> Most families and children tolerate these stresses without significant problems and are similar to other families experiencing relocation and parental absence. However, it is important to remember that most military families are geographically distant from their extended family networks. Service members work long hours and are expected to give full attention to mission accomplishment. In order to accomplish unique military tasks, a necessary culture of authoritarianism is intrinsic to the infrastructure of the military.<sup>13</sup> Although an effective form of getting military missions accomplished, the authoritarian approach when carried over into family dynamics may worsen stress and family function.

As the length of duty increases, or the perception of danger because of military

operations increases, stress levels increase to more moderate levels. Military families are exposed to recurrent deployments where the military member can be away from the family for periods of 12 to 18 months at a time. Although the parental absence is difficult, the perceived danger to a military parent can increase family distress significantly. Ultimately, stress levels can be pushed into the severe or “toxic”<sup>8</sup> range while military members incur severe injuries as a result of their service and return home for treatment, rehabilitation, and reintegration into civilian society. Extreme distress occurs when service members die while performing their military jobs. The spectrum of stress (typical, tolerable, toxic) of American military families serves as a specific model to consider graduated lev-

*As the length of duty increases, or the perception of danger because of military operations increases, stress levels increase to more moderate levels.*

els of stress. Other examples might include exposure to natural disaster, relocation, and more common situations, such as school failure, divorce, or living with illness.

#### **HOW CAN A PEDIATRICIAN MAKE A MEANINGFUL IMPACT ON THE EFFECTS OF FAMILY STRESS IN DAILY PRACTICE?**

- Start by seeking personal learning opportunities through continuing medical education (CME) on childhood stress and its management. As the practice is developed into a medical home where patients and families return for frequent comprehensive care, encouraging families to think of it as a place to gain knowledge about their emotional as

well as their physical health, will come naturally.

- Encourage families to be open with the life stressors that may be bothering them.
- Provide patient handouts and play multimedia messages throughout the office setting that help families understand the health effects of stress on their lives.
- Display and promote the message that families can learn protective resilience skills and that professionals and community resources can help out when stress is starting to get out of control.
- Group well care and related support groups may allow better exchange of parenting information and social interventions that have longer lasting effects.<sup>14</sup>
- Consider implementing routine screening for behavioral/emotional problems with instruments such as the Pediatric Symptom Checklist, which has been shown to increase the rates of mental health referrals significantly.<sup>15</sup> Screening tools can provide valuable information to providers for “next steps” after they hear the presenting complaint. Ultimately, a practice may consider co-locating with a mental health specialist, such as a child psychologist or a licensed clinical social worker.

Sidebar 4 (see page 437) demonstrates an example of how to translate these concepts into practice using the military family model presented earlier.<sup>16,17</sup>

#### **RESILIENCE: A PROACTIVE APPROACH TO LESSEN STRESS**

Risk behaviors should be addressed directly through assessment, anticipatory guidance, and referral. One way pediatricians can help children and adolescents cope with daily or extreme stress is through promoting resilience, that is recognizing and building on patients’ strengths. In *A Parent’s Guide to Building Resilience in Children and Teens*,<sup>18</sup> Dr. Kenneth Ginsburg synthesizes the resilience literature into

meaningful suggestions that parents and clinicians can easily implement. He emphasizes that children will live up, or down, to the expectations of adults in their environment. The author suggests promoting the “seven Cs of resilience” as a way to help well functioning families thrive despite adversity. This strategy also provides a way to begin to guide families out of stressful routines (see Sidebar 5, page 437).

#### **CONCLUSIONS**

Pediatricians can provide the spark for family systems change. Patients and families look to their pediatrician for guidance, motivation, and to be a touchstone of reassurance in times of stress and crisis. Focusing on one of the critical seven C’s at each visit with families is one way to help manage stress in the lives of children. Promoting competence in families is the process of helping them focus on their inherent strengths while shifting focus away from their weaknesses and failures. Too often, clinicians are quick to point out the deficits of patients and their families. This often only generates shame and a lack of confidence in those they are trying to help. Pediatricians can help families learn how to notice the positive and uplifting aspects in other family members and to look diligently for and accentuate these qualities when they are searching for solutions. Promoting genuine confidence by encouraging families to set reasonable expectations for each other is another role of the pediatrician when managing stress. Parents may need to learn that it is OK at times for their children to fail, that there are valuable lessons from the experience of failure, and the process of “getting back up after facing challenges.” On this note, it might be appropriate for the pediatrician to encourage parents to let down their own defenses and to share their own imperfections and vulnerability with older children, from time to time.

SIDEBAR 4.

### Practical Strategies to Address Military Childhood Stress

Learn about the unique aspects of military family culture<sup>16</sup>

Learn about the emotional cycle of military deployment<sup>17</sup>

Identify resources to assist military families (such as [www.MilitaryOneSource.com](http://www.MilitaryOneSource.com), [www.aap.org](http://www.aap.org), and "Helping Children and Adolescent through the Difficulty of Deployment in the Family" found at [www.aap.org/sections/unifserv/deployment/index.html](http://www.aap.org/sections/unifserv/deployment/index.html))

Screen families during clinical encounters for exposure to military deployment and relocation stress

Utilize screening tools in well child visits, such as the Pediatric Symptom Checklist

Start a peer-to-peer support group in your practice for older children, adolescents, or parents who may be experiencing stresses of military family life

Integrate guidance on building resiliency into clinical encounters

Advocate for enhanced support services (school counseling, drop-in day care)

Educate community organizations on military family support issues

SIDEBAR 5.

### Seven Cs of Resilience

**Competence:** the ability or know how to handle situations effectively; is best acquired through actual experience

**Confidence:** the solid belief in one's own abilities; is rooted in competence; is best gained by demonstrating competence in real situations

**Connection:** having close ties to family, friends, school, and community as a way to promote a solid sense of security and promote strong values; is helpful in preventing children from seeking destructive alternatives to love and attention

**Character:** a fundamental sense of right and wrong that ensures that children are prepared to make wise choices, contribute to the world, and become stable adults

**Contribution:** children who contribute to their families and communities gain a sense of purpose and surround themselves with people who have high expectations of them

**Coping:** learning positive, adaptive ways to handle stress

**Control:** realizing that one is in charge of the outcomes of their decisions and actions

From Ginsburg KR, Jablow MM. *A Parent's Guide To Building Resilience in Children and Teens: Giving Your Child Roots and Wings*. American Academy of Pediatrics; Elk Grove Village, IL; 2006:1-26.

Encouraging families to seek connections among themselves and among other institutions in their community, such as in their school or religious organizations, is important. Being connected builds strong social skills and fosters important values that can be drawn upon in difficult times. At anticipatory guidance visits, pediatricians should encourage every child, and family member for that matter, to have at least one adult and/or peer with whom they can have safe rela-

tionships, who can be called upon during times of stress or celebration. Likewise, encouraging patients to develop a strong sense of character with the help of their parents and friends is a form of resilience. Children with character enjoy a strong sense of self worth and confidence that they can draw upon during times of adversity.

"It is a powerful lesson when children realize that the world is a better place because they are in it."<sup>18</sup> Chil-

dren who understand the importance of personal contribution gain a sense of purpose that can motivate them. Promoting positive coping strategies is also helpful for families. Help them understand that there are many strategies to cope with stress, but that not all of them are healthy and productive. Finally, when families understand that they can control the outcomes of their decisions and actions, they're more likely to know that they have the ability to do what it takes to "bounce back." Pediatricians can be one community resource to help them get rid of the feeling that things always happen to them and replace that feeling with the belief that they can control what happens to them through their choices and actions. Promoting the seven Cs, as a matter of practice, while addressing the other concerns of children and families can be anticipated to pay dividends as families face increasing stress and life challenges.

Pediatricians are increasingly asked to address the spectrum of stress and crisis in patients and their families. This complex challenge is greater than many have faced in past years of practice and holds the potential of being overwhelming. However, if we are to live up to our mission, we must rise to meet the challenge. Pediatricians know better than anyone else that children and adolescents are the foundation of the future. Pediatric professionals play a critical role in safeguarding the passage of children and adolescents into a functional and productive adulthood. As pediatricians draw upon their innate professional strengths and take time to develop the skills that will help better serve children and their families, they will be solidly investing in the healthy future of the nation.

### REFERENCES

1. Ringel JS, Sturm R. National estimates of mental health utilization and expenditures for

- children in 1998. *J Behav Health Serv Res.* 2001;28(3):319-333.
2. American Academy of Pediatrics. Committee on Psychosocial Aspects of Child and Family Health. The new morbidity revisited: a renewed commitment to the psychosocial aspects of pediatric care. *Pediatrics.* 2001;108(5):1227-1230.
  3. American Academy of Pediatrics. Committee on Psychosocial Aspects of Child and Family Health. The pediatrician and the "new morbidity." *Pediatrics.* 1993;92(5):731-733.
  4. Hagen JF. The new morbidity: where the rubber hits the road or the practitioner's guide to the new morbidity. *Pediatrics.* 2001;108(5):1206-1210.
  5. Sharp L, Pantell RH, Murphy LO, Lewis CC. Psychosocial problems during child health supervision visits: eliciting, then what? *Pediatrics.* 1992;89(4 Pt 1):619-623.
  6. Shapiro S, German PS, Skinner EA, et al. An experiment to change detection and management of mental morbidity in primary care. *Med Care.* 1987;25(4):327-339.
  7. Accreditation Council for Graduate Medical Education. Program requirements/Pediatrics-competencies. Available at: <http://www.acgme.org>. Accessed Feb 8, 2007.
  8. Shonkoff J, Phillips D. eds. *From Neurons to Neighborhoods: The Science of Early Childhood Development.* Washington, D.C.: National Academy Press; 2000.
  9. Campo JV, Jansen-McWilliams L, Comer D, Kelleher KJ. Somatization in pediatric primary care: association with psychopathology, functional impairment, and use of services. *J Am Acad Child Adolesc Psychiatry.* 1999; 38(9):1093-1101.
  10. Kelleher KJ, McInerney TK, Gardner WP, Childs GE, Wasserman RC. Increasing Identification of Psychosocial Problems: 1979-1996. *Pediatrics.* 2000;105(6):1313-1321.
  11. Mayer JD, Caruso DR, Salovey P. Emotional intelligence meets traditional standards for an intelligence. *Intelligence.* 2000;27(4):267.
  12. Chartrand MM, Siegel B. At war in Iraq and Afghanistan: children in U.S. military families. *Ambul Pediatr.* 2007;7(1):1-2.
  13. Wertsch ME. *Military Brats: Legacies of Childhood Inside the Fortress.* Putnam Valley, NY: Aletheia Publications; 1991.
  14. Taylor JA, Davis RL, Kemper KJ. Health care utilization and health status in high-risk children randomized to receive group or individual well child care. *Pediatrics.* 1997;100(3).
  15. Briggs-Gowan MJ, Horwitz SM, Schwab-Stone ME, Leventhal JM, Leaf PJ. Mental health in pediatric settings: distribution of disorders and factors related to service use. *J Am Acad Child Adolesc Psychiatry.* 2000;39(7):841-849.
  16. Cozza SJ, Chun RS, Polo JA. Military families and children during Operation Iraqi Freedom. *Psychiatr Q.* 2005;76(4):371-378.
  17. Pincus SH, House R, Christenson J, Adler LE. The emotional cycle of deployment: A military family perspective. *U.S. Army Medical Department Journal.* 2001;4/5/6:15-23.
  18. Ginsburg KR, Jablow MM. *A Parent's Guide To Building Resilience in Children and Teens: Giving Your Child Roots and Wings.* Elk Grove, IL: American Academy of Pediatrics; 2006:1-26.
  19. Ginsburg KR, American Academy of Pediatrics Committee on Communications and Committee on Psychosocial Aspects of Child and Family Health. The Importance of Play in Promoting Healthy Child Development and Maintaining Strong Parent-Child Bonds. *Pediatrics.* 2007;119(1):182-191.
  20. Hagan JF, American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health and the Task Force on Terrorism. Psychosocial Implications of Disaster or Terrorism on Children: A Guide for the Pediatrician. *Pediatrics.* 2005;116:787-795.
  21. American Academy of Pediatrics. Committee on Early Childhood, Adoption, and Dependent Care. The Pediatrician's Role in Family Support Programs. *Pediatrics.* 2001;107:195-197.
  22. American Academy of Pediatrics. Committee on Community Health Services. The Pediatrician's Role in Community Pediatrics. *Pediatrics.* 2005;115:1092-1094.
  23. American Academy of Pediatrics, Committee on Psychosocial Aspects of Child and Family Health. The Pediatrician and Childhood Bereavement. *Pediatrics.* 2000;105:445-447.