

Understanding and Overcoming the Influences of Poverty on Children and Families

October 17, 2014 (World Poverty Day)

Brought to you by the APA Offices on Socioeconomic Status
and Violence Prevention

Co-host, Keyona King-Tsikata (KKT):

Director, APA Office on Socioeconomic Status

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202.216.7601

Hello, and thank you for joining us on this Friday afternoon, October 17th, in commemoration of both World Poverty Day and the year-long commemoration of the 50th anniversary of the War on Poverty. My name is Keyona King-Tsikata. I am the Director of the Office on Socioeconomic Status, and I'm joined by my colleague Julia Silva, Director of the Violence Prevention Office of the American Psychological Association. We welcome you and are excited to present this webinar, titled "Understanding and Overcoming Influences of Poverty on Children and Families."

In short, our esteemed panelists will discuss how poverty as a toxic stressor gets under the skin, its consequences, and how to mitigate its effects. We are joined today by Dr. Daniel Marston, who is a cognitive behavioral psychologist and owner of Marston Psychological Services, LLC. His research and training interests are primarily in the areas of neurological and psychological effects of poverty. We are also joined by Dr. Roseanne Flores, who is a developmental psychologist and Associate Professor in the Department of Psychology at Hunter College of the City University of New York. Her research examines the effects of poverty on children's cognitive and linguistic development, the influences of parent-child discourse practices, and the relationship between environmental risk factors such as community violence and food insecurity on the health and educational outcomes of minority children.

Again we welcome you. We are very excited to report that we have over 1,000 registrants for this webinar. Please note that all participants will begin the webinar muted, and will not be able to be heard. If you have questions, please write them in the questions tab of the Go To Webinar navigation bar. Also, we have allotted the last 15 to 20 minutes of the webinar for questions and answers. We want this to be an interactive opportunity for you to be able to also ask and have our panelists respond to your questions. So please do take advantage of writing your questions in the questions tab. Furthermore, this webinar is being recorded, and it will be made available online at apa.org. In the event that we're not able to get to a large number of the questions that are asked, we will do our best to have a short question and answer supplemental sheet that goes along with the recorded webinar. And without further ado, I am going to go ahead and turn the webinar over to our first esteemed panelist, Dr. Daniel Marston.

Dr. Daniel Marston (DM):

Marston Psychological Services, LLC

Hello everybody. My name is Dr. Marston, and I am going to be talking about the neurobehavioral and

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psychological effects of poverty. As Keyona said, I'm Dr. Daniel Marston, I'm the owner of Marston Psychological Services, LLC in North Huntingdon, Pennsylvania. I am board certified in cognitive behavioral psychology. I am the owner of a practice that provides services in low-income areas throughout southwestern PA. I'm a licensed psychologist, I specialize in the assessment and treatment of neurobehavioral disorders, I am a member of APA's Division of Behavioral Neuroscience and Comparative Psychology, and I am that Division's representative, otherwise called monitor, to APA's Committee on Socioeconomic Status who is sponsoring this presentation.

In this presentation, I will be reviewing statistics related to poverty and neurobehavioral and psychological disorders, I will be addressing factors associated with poverty and neurobehavioral and psychological disorders, I will be addressing neurological issues that are associated with poverty and their impact on behaviors, and will also be addressing ways that psychologists and other mental health professionals can help address those issues.

In 2011, the US Census Bureau estimated that there were 46.2 million people living below the official poverty line set by the government.

The National Center for Children in Poverty this year came out with statistics showing that 20% of children live in poverty. That translates to more than 16 million children. Another 25% live in what would be considered "near poor," which is 100%-200% of the poverty level.

What will be the essence of this presentation is addressing the higher prevalence of neurobehavioral and psychological disorders in individuals who are suffering in poverty. I have a summary of a research article there from the Journal of Neurology, where the author studied the prevalence of intellectual disabilities across the world, and found that intellectual disabilities occurred 3-5 individuals per 1,000 individuals in high-income countries, but almost 7x as often in developing countries—22 out of 1,000 individuals. And this would just be an example of the higher prevalence, and how significant it is in areas where poverty is more prevalent.

Moving on to additional research. Hetzner, Johnson, and Brook-Gunn in 2010 found considerable evidence that children from poor families were more likely to experience developmental delays than individuals from middle class families.

The National Health Interview Surveys found that family poverty was associated with significantly higher levels of developmental disabilities, learning disabilities, and intellectual disabilities. This would just be an example of research showing the significantly higher prevalence of neurobehavioral disorders in families suffering from poverty.

An additional part of that research was they looked at medical assistance and compared it to children who were being treated under private insurance and found that children who were being treated under medical assistance had higher levels of ADHD, learning disabilities, intellectual disabilities, and

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developmental disabilities, which would be the category of autism. And this is relevant because all of those would be under the category of neurobehavioral disorders, which are behavioral disorders that have a significant neurological aspect to them.

I have here, again, research showing higher prevalence of ADHD among children below the poverty level. The research I've reviewed up 'til now has just been sort of an overview of the more significant numbers of neurobehavioral disorders in children suffering poverty. We'll now move on to discussing some of the neurological and psychological factors associated with poverty that may help to explain that higher prevalence.

There was a recent article in American Psychology that reviewed how poverty is a critical risk factor for many mental, emotional, and behavioral disorders in children. And that research found that poverty was highly related to mental, emotional, and behavioral health disorders, independent of such things as parental education, race or ethnicity, and neighborhood conditions—so really underscoring that it was poverty, and factors associated with poverty, that explained the higher prevalence.

Some of the psychological problems that were found to be more prevalent and associated with poverty were anxiety, depression, attention problems, and disciplinary problems.

What these authors, Santiago, Wadsworth, and Stump—and I apologize, there's a small error, that should be 2012, not 2002—what they found was that adults in poverty showed a higher level of withdrawal, semantic complaints, and thought problems, pervasive negative thinking being an example of that.

These same authors then found that with children, the problems that were higher and associated more with poverty were social problems, attention problems, and attention and depression problems. What these authors and some other authors have explored is a possible underlying psychological issue—and that was that adults suffering poverty, many of whom are taking care of families, tended to be more impacted by worry and anxiety about what they were supposed to do and how they were supposed to handle the many stressors associated with poverty. Children, on the other hand, tended to be more impacted by feelings of helplessness and lack of control. They often see what their families were going through and feel they need to be of some help, but can't really identify any way of helping or having any control over the situation. In my own practice, we see this quite often—adults tend to be very focused on trying to figure out how to handle the problems; children, on the other hand, are very much impacted by wanting to have some control over the stressors, or trying to figure out some way to help their families deal with the significant stressors. And this is one way of explaining how with adults, many of the symptoms related to poverty are ones that tend to lean more in the anxiety area, whereas with children they tend to lean more in the depression area.

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Some of the physiological factors and psychological factors that have been associated with poverty and may explain some of the higher level of neurobehavioral and psychological disorders include such things as malnutrition, environmental factors, stress, and lack of resources.

Some of the possible explanatory factors for why you would have higher levels of disorders when you get into some more specifics include protein energy malnutrition, dietary deficiencies, environmental toxins, and lack of early sensory stimulation.

What we're getting into now are some of the more specific physiological factors that may lead to the neurobehavioral disorders and the higher prevalence associated with poverty. Maternal malnutrition is one of them—it tends to significantly impact communication and social disorders; also contributes to a higher level of developmental disabilities.

Lower brain volume in the hippocampus and amygdala tend to be associated with poverty and could be a physiological explanation of the higher level of neurodevelopmental disorders.

You see here another author, Evans and Schamberg, going through the findings that poverty is often associated with impairments in the hippocampus and amygdala, and often lead to problems with working memory.

Wilber and Wilber's colleagues have found a considerable amount of evidence about chronic stress and its impact on individuals in poverty. And this significantly impacts on the prefrontal cortex. Some other possible physiological factors that are related to impairments in the prefrontal cortex include deficits in executive functioning, cognition, language, sociability, and emotion.

Farah, who is at the University of Pennsylvania and is certainly one of the most prominent names in studying the neurological impact of poverty, really found the strongest evidence of how the prefrontal cortex is impacted when it comes to poverty. This actually helps to explain a large degree of the neurobehavioral disorders. You see here some additional evidence about how the prefrontal cortex impacts executive functioning when it comes to poverty.

Poverty is associated with increased stress physiology, and I have here a summary of some research addressing that. Chronic stress has a significant impact on the hippocampus, which really can affect how individuals deal with new challenges and handle stressful situations. Chronic stress, and its relation to poverty, has in the end really been found to be a significant factor when it comes to neurobehavioral disorders and poverty.

Some of the chronic effects that can be associated with the high level of stress and poverty include maternal deprivation, nutritional deprivation, noise problems, housing problems, and diminished cognitive enrichment. So what we have here is, these are the factors associated with poverty that really

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impact significantly on the neurodevelopmental factors associated with childhood, and really impact on the development of neurobehavioral disorders.

So in the end, what we have here is poverty relates in large part to impairments in the hippocampus, amygdala, prefrontal cortex, and relate directly on executive functioning, working memory, social comprehension, and emotion regulation. This then leads to higher levels of autism, learning disabilities, ADHD, and intellectual disabilities.

Poverty, and the chronic stress associated with poverty—Fuller et al. in 2012 found that 13% of that could be related directly to perceived social class discrimination. Individuals in poverty often are under a lot of stress because they perceive themselves as being treated differently because they are poor, and this is often because they actually are treated differently because they are poor. That involves a considerable amount of stress, which impacts significantly both on psychological and neurological development.

Moving here forward on the issue of access to behavioral health services—many individuals in poverty lack access to behavioral health services and often this is because they do not recognize the need for it. Mental health services are seen as a specialized service and many families do not see the need for this beyond what they already get from their medical practitioner.

There has not been found to be many types of approaches that really help to address the impact of poverty, but some ways that are likely to be helpful include: Head Start, as they address developmental and behavioral problems early; services that are more convenient for families; comprehensive assessment strategies that are cost effective and time-limited; helping children and adults with coping skills; helping children with feelings of helplessness and helping adults find ways of obtaining needed resources and stress management; offering multiple types of assistance; helping to address nutritional deficits; showing recognition of the complex issues that are involved; and also taking a non-judgmental attitude to people suffering in poverty. That is the end of my presentation, and I thank you very much for listening.

Dr. Roseanne Flores (RF):
Hunter College

Good afternoon everyone, I'm going to be addressing the influence of poverty on children and families in the context of communities. So I'm going to begin with a story about Michael and Gabriel, because I think it's important to lay the context for what I'll be talking about this afternoon. Michael and Gabriel are 18 year olds, and they're expecting the arrival of their first child. Michael is in the process of completing high school, and Gabriel has stopped going because she's been sick throughout her pregnancy. Michael works part-time while going to school, and still lives at home with his family. His parents are older now, and no longer work. Because he does not have a full-time job, he does not have

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health insurance. He's trying to finish school so he can get a full-time job, and save enough money and move out of his parents' home. He wants to support himself and his new family. Gabriel lives at home with her mother, who is struggling to take care of Gabriel and her baby sister. They have a small apartment, and the rent has just gone up. Gabriel's mother is worried, because she does not know how they will take care of the new baby. Gabriel is unable to work because she's been sick, although she sometimes watches her younger sister so her mother does not have to pay for child care. Gabriel goes to a health clinic when she can, but she sometimes skips appointments because she does not have enough money to get to the clinic. Michael and Gabriel are anxious, because they do not know how they will support their new baby. They want to be good parents, but they don't know how they will be able to make it under the circumstances. If things get worse and nothing changes, the new baby will be born into a family living in poverty.

So today for my presentation, what I want to do is look at families and children living in the United States in poverty, talk about the individual and structural determinants of poverty, look at the cycle of poverty and families, address some of the indicators of child wellbeing, examine the consequences of poverty on child and family wellbeing, and then talk about fostering resilience in children and families.

As you can see looking at the Federal Poverty Guidelines, for a family of four living at 100% of the federal poverty line, that consists of making approximately \$24,000 a year. At 133%, it's about \$31,000, \$35,000 at 150%, and approximately \$48,000 at 200% of the federal poverty line. I want you to sort of keep that in mind as I go on throughout the talk.

We're going to talk about some facts about family poverty in the United States. Families living between 100% and 200% of the federal poverty level are at risk for missing rent and bill payments, not having access to adequate child care, running out of food, and having poor quality health. Single parent families have a greater risk for experiencing economic hardship than children living in two parent families. Lower levels of parental education also contribute to lower income and to poverty.

As you can see using data from the Annie E. Casey Foundation, all families from 2009 to 2013 were living approximately at 15% of the poverty level, with a dip happening at 2013. But if you look at single-parent families, they're at the highest level at the 35% mark, and they were pretty stable from 2012 to 2013. Married couples also have a high level of poverty, but the dip starts to happen again in 2013.

Some facts about child poverty—children growing up in poverty are at the greatest risk for experiencing poor developmental outcomes, some of which you heard in the previous presentation. They're at risk for having poorer health care and nutrition so many children will suffer from food insecurity or not having access to food in a proper and socially desirable way. They're at greater risk for experiencing poor health outcomes, whether at the level of asthma or other health conditions. In terms of education, they have poorer educational, positive, and social-emotional outcomes as you just heard. And they also have limited access to high quality education, and that's from birth throughout the college years.

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They're also at the greatest risk for experiencing abuse and neglect, as well as being at greater risk for being exposed to and victims of violence. Children at the 100% poverty level, as you can see from the statistics—from 2009 to 2013, sort of increased at 2012 and then dipped a little bit in 2013, but they're still pretty high at 20%.

Children living in areas of concentrated poverty—and that's where you'll have neighborhood overcrowding, pollutants, toxins, and the like—have increased over time. From 2000 to 2012, you see an increase of children living in areas of concentrated poverty.

Now what I want to do is to talk about some individual and structural determinants of poverty. We sometimes think about this in the context of determinants of health, but I wanted to frame it in the terms of the context of poverty. When you look at individual determinants, what you have are limited access to education, fewer financial resources, fewer social resources, poorer health, greater exposure to stress, and limited income. But those are actually related to the structural determinants. You have limited access to quality health care, poorer neighborhoods, limited access to high quality education, limited access to high paying jobs, insufficient housing, and higher exposure to community violence. So those two things are actually interrelated—the structural affects the individual, and vice versa.

When you start to address the cycle of poverty and families, what you can see is that poverty affects family circumstances, which are also affecting poverty, and then family circumstances affect child wellbeing, which is also affected by poverty.

When you look at the indicators of child wellbeing, we have six dimensions that we need to think about. We need to think about material wellbeing, housing and environment, education, health, risk behaviors, and quality of school life. When you think about that, those are some of those structural determinants that I spoke about previously, but that also affect the individual determinants.

Let's talk about some consequences of poverty on child and family wellbeing. We've talked about this before—poverty is viewed as a toxic stressor or a chronic stressor. Exposure to ongoing stress can result in chronic exposure to violence, limited access to economic resources, severe poverty, instability within families and communities, and all of these affect child and family wellbeing. Families living in poverty tend to live in overcrowded neighborhoods, their environments are exposed to chemical toxins, they have communities with limited cultural, social, and financial capital, and they have a greater exposure to violence.

When you have an accumulation of all of these factors together, so it's not just one risk factor, you end up with poorer health outcomes for both children and families.

So what can we do? I want to suggest that children and families, just like toxic stress—not all children or families exposed to toxic stress will actually end up in a place of poverty for all of their lives, but for the most part, some children and families may be resilient. We have to talk about this notion of resiliency

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and working to support children and families. Resilience is going to involve the ability to do well in the face of adversity and trauma. Resilience is not innate, and it can be fostered in children and families, and that's important to understand.

So how can we help to foster resilience? We can start at the individual level—it should be fostered at the individual level and working with children to develop problem-solving skills, social competence, and confidence. At the family level, it should be fostered by working with families to develop warm and engaging relationships and social support. At the community level, it can be fostered by helping children and families develop supporting relationships with members of the larger community. When we look at this group, we can no longer just look at it at the individual determinant level, we must look at it as an integrated whole. Supporting family and child wellbeing is going to take an integrated approach. We need strong communities, and those strong communities then will relate to strong families, and those strong families will relate to thriving children. At the end of the day, what we want to have is a family that's supported by all so that by supporting an integrated family and members of the community, families like Michael and Gabriel will have a fighting chance. And with that I'm going to end so we can open it up for some questions.

KKT: Wonderful, thank you so much Dr. Flores and Dr. Marston. We do have some questions that we'll start with. The main question that people have been asking is whether or not the slides can be made available, and the answer to that is yes, our office can definitely send that information out to the registered participants via email so you can have access to those slides. The other question is about the presentation—I mentioned this earlier at the very beginning that yes, this webinar is being recorded and it will be available at a later date on our website. It will not be in the next couple of days because there is a process where everything has to be transcribed before it is made available on our website. Once the transcription is available, and everything has been approved through our ITS department, it will be uploaded. My guess is that could take about two weeks, so hopefully within that time frame.

So now questions for our panelists. The first question is *what are some optimal standardized measures of SES to use in research?* I have used Hollinstead's previously but it is also outdated.

RF: I would answer that question by saying that in fact, for me, I use large datasets and more often than not composite variables are made so that we don't just have a straight standardized variable—you're creating the variable with income, education, and the like. I would think that depending on what kind of research you're doing, sometimes if you're using large datasets those variables are made already.

KKT: Next question. *Is there a control for the statistic of children in poverty that do have higher levels of mental health issues, in that these children are more likely to be involved with social services which includes psychological testing, or they are involved in the criminal justice system that requires treatment, whereas children in higher income households are less likely to be involved in these services? Parents in*

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poverty and lack of education are more likely to have behavior problems with children that lead to services, that lead to diagnosis.

DM: My strongest response to that—and this is something I think is very important—it is not the case that just because someone is in social services or in the criminal justice system, that they are receiving quality mental health services or mental health assessment. That would be my general statement, that what has come out from the research on these programs, and I had done a whole presentation on assessment, which is something I mentioned here—what has come out in the research is that assessments being done were not high quality ones. You could find many, many programs for social services and the criminal justice system where the person doing the assessment is not even a psychologist. Now that doesn't always mean that the assessments are bad, but certainly psychologists are the ones primarily seen as most trained in doing psychological evaluations. Or they were not even licensed mental health professionals. What has come out in the research when they reviewed these programs is a high level of inconsistency in social services and in the criminal justice programs of the quality of evaluation and services that are being provided.

RF: I also think part of the question is something about a control and who would be part of the group and who would you be missing—if I got that right, I think that's part of the question. I think yes, when you're looking at the data, particularly the kinds of data I was talking about today, which is national level data, you're sometimes missing a group of individuals who don't access services so they wouldn't be part of the dataset. They may be being caught by private mental health providers and the like, but they might not be part of the overall system. So yes, when you're looking at data you have to think about that.

KKT: *Are the physiological effects thought to be because of the poverty, or actually lead to poverty? For example, the hormone levels, memory issues, smaller hippocampus?*

DM: The research that I reviewed and the most prominent research—and certainly the article in the American Psychologist that came out just recently, the one I cited in the presentation—would really underscore that it is the impact of poverty that leads to these problems in part. Part of why I say that so directly is because much of the study on the neurological impact has been on child development. In fact, one of the articles I cited there on the stress level was before one year of age when it started, so this is where a lot of the studies of impact of poverty come from, and certainly studying children would suggest that its poverty impacting on them, rather than their development leading to poverty. I would say that the research strongly leads in support of stating that it is the impact of poverty that leads to these factors. Now, there's certainly a circular nature to it, that individuals—in fact, that could be seen as one of the major problems, that it can lead to being trapped in a cycle. Poverty leads to the development of, say, intellectual problems, developmental problems, attention problems, and then that might make the individual less likely to get out of poverty, to do the things that they would need to get out of poverty, and thereby leading to a circular nature to it. That would be a factor as well.

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RF: I would agree, and I think that's what when I was talking about those individual determinants versus the structural determinants and the interaction between them. There are things that the individual comes with, but then the environment affects that and that becomes the cycle. The poorer access to education is going to lead to poorer job skills, which is going to lead to poorer outcomes, so then it becomes a cyclical process on top of the stressful foundation.

Co-host, Julia da Silva (JD):

Director, APA Violence Prevention Office

<http://www.apa.org/pi/prevent-violence/>

202.336.5957

Hi, this is Julia da Silva, I'm the Director of the Violence Prevention Office. I just wanted to add something to this discussion. The association between poverty and harsh parenting practices—that is the association also that you see that parents who are stressed by the level of poverty, helplessness, difficulties, mental health issues, and lack of social support—they are more likely to use harsh punishment and harsher discipline with their kids, and many times you'll see physical discipline. This is one of the issues that there is extensive literature on in terms of the connection between poverty, stress in the family, and un-effective harsh parenting styles and child maltreatment leading to those outcomes. Also negligence, because neglect is a very important consequence of poverty. Families who cannot provide basic needs for their kids—this also has outcomes for the kids. I just wanted to make all these connections, that poverty is a social determinant of situations that have continuing influence and impacts on children's behavior. It's important for us to have a clear idea of what are the chain of events and associations, so we can understand the children's outcomes in very low-income, stressful, and toxic environments.

RF: I would agree, and hence why I also want to say that if you look at the resiliency component of that, which then is providing the support for families so that they can provide the support for their children. That comes at the community level of addressing community violence, which will then fix some of the neighborhood and then provide support for families, and those families will provide support for their children. We want to move away from this notion of mental illness and into looking at child and family wellbeing, and that child and family wellbeing will happen in the context of all of those areas. We can draw on that resiliency factor, of how we can help children and families in the context as we try to shift some of those other determinants.

KKT: Related to the answer of that question, *what are some resources that we can share with families about building resilience? Can you give us some examples of where we can find this?*

RF: Well the APA, the American Psychological Association, has a great deal of resources online for resiliency. Julia, you can also talk about the Violence Prevention Office and the resources that you have

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available. I will also advocate that folks look at Head Start to look at the notion of strengthening families and how we can support families and family engagement. I think that's also a big part of this as well.

KKT: Wonderful. The next series of questions have to do with schools and programs in schools. Part of that is *what are some of the evidence-based practices in schools, and how do we get families invested in encouraging their children to participate in these school programs?*

DM: Working a lot with schools, in a lot of ways, that's the million dollar question. There are these great programs out there, but sometimes getting families involved and committed to it can be very difficult. My experience, my review of the research, would all point to: if there's a disconnect between what the people running the programs are hoping to do and what the families who are being looked to in terms of participation, if there's a disconnect, it's often that the families do not see the real practical benefit. The question of "how really is this going to help me" is something that they don't necessarily see. It's certainly a complex issue, but what I would say is that if there's an area to focus on, its figuring out how to make it practical as far as use, and being very clear and specific on what this is likely to do, and also making it—and I also mentioned this in the presentation—as convenient as possible.

RF: I would also argue that the federal government, for example, has some grants such as the Promise Neighborhood grants, that would go from birth to college and you would obviously look at strengthening the neighborhoods. I go back to this notion of communities—schools are part of the larger communities in which people live, and so as you strengthen neighborhoods you provide resources, and you provide change in structures. This also benefits the children, and it's linked to the schools. SAMHSA also has some grants—Project Launch, for example—the integration and coordination of early childhood services. So things of that nature would be the ways that I think people who work within communities and schools can foster development in children and support families.

KKT: Thank you. Next question: *In your research, have you found differences between rural and urban poverty and children and families?*

DM: Yes, very often, mainly in the area of—not necessarily the actual neurobehavioral impact of poverty, but more in the benefits from services, primarily related to the whole issue of lack of access. If there's one issue that I've seen really be the distinguishing factor between rural and non-rural areas, it's the issue of access.

RF: I would say that particularly, again if you're looking at children, very young children, and children and families, is there's been a tremendous amount of work on that, which basically gets at that point, that children in rural areas have limited access and fewer things available to them than children in urban areas do, and sometimes greater health disparities as well, because of that.

KKT: *What one thing can social services agencies do to increase resiliency in these children and families? If there had to be one thing, what would be the most important thing?*

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RF: From my perspective, I would argue that building supports through nourishing and fostering relationships, because those relationships are going to be the foundation for not only families but for children. And I mean those relationships outside of the family, so connecting families to community supports, which then provide those supportive resources that families are sometimes lacking. That gets back to the earlier issue of harsher discipline and more violence. When you're stressed, you don't have access to those supports, so I would argue that building those supports, building those relationships, which then could help to strengthen families and children.

DM: I would say provide consistency, in whatever way you define that, as much as possible. Even if you have a small number of resources, if you can make it clear that this is going to be provided on a consistent basis and in a consistent way, that seems to be the one thing that helps the most.

RF: On the back of that question, one of the things I didn't address during the presentation because there are a lot of things to do is the issue of consistency, and that was an issue that was raised before about families and children. We know that routines are important in the lives of children and families, and sometimes families living in poverty don't have those nice and stable routines because they're either juggling or balancing jobs and don't have access to proper childcare so they're scrambling around for that. Again, providing those supports can help families provide routines for their children, and we know that those routines are necessary for good development in children, such as eating practices and family meal time.

KKT: Dr. Marston, *could you expand a bit more on the connection between poverty and autism?*

DM: Yes, I in fact did a presentation on this specifically a while ago. The connection between autism and poverty actually has been sort of up and down as far as where the evidence points. There actually was at one point quite a bit of evidence suggesting that there might be less autism in poorer areas. It wasn't quite clear why that would be the case, and further research indicated that it was more an access to services type issue. What it really comes down to is, there does seem to be a higher rate of autism among poorer families, and autism is a neurological condition first and foremost—it's a neurobehavioral disorder. So because poverty affects those areas of the brain that are most related to autism, there would be a lot of reason to believe, a lot of support, for there being a higher level of autism in poorer communities. So my general statement to that, but also hopefully expanding is, autism is a neurological condition, the parts of the brain that are most directly related to autism are also ones directly impacted by poverty, and that would be a supporting factor for why there does seem to be a higher level of autism in poorer families.

KKT: I'm going to change gears a little bit. *What are some effective methods to improve community level resiliency?*

RF: Again, this is about partnerships. If you think about communities, part of working within communities would be getting everybody on-board—because poverty, as we know, is multi-integrated.

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It's not just a one prong approach to dealing with it. So that would be partnering with businesses, that would be partnering with the federal government, and that would be partnering with private institutions to build communities that would support families. Part of that is as you build the communities up, families may then be able to have access to jobs, and that access to jobs would provide the income, so that they could actually use the income to provide for their children. So I think it's about building partnerships, and that's the supports in the community. One of the other factors that wasn't raised is that this is about social and emotional, physical and spiritual health, so it's also drawing on those resources in the community—the houses of worship that are in the community, bringing those folks onboard so that maybe they can provide additional support for families. I think everybody needs to be onboard—it's sort of like getting everyone to the table and then working with that group to say, "Okay, what can we do support children and their families that will ultimately support the community."

KKT: Thank you. *How do we know that children in poverty are exposed to violence? I thought violence was evident across SES?*

RF: Well, yes it is across SES, but when you look at the statistics for neighborhoods in terms of violence, you actually see higher levels of violence in impoverished communities, and some of that might be due to limited resources and what's available, and what's not available. The data talks about that. If you think about areas that are really impoverished, where we have concentrated poverty, so then what resources are available within those communities. I sort of alluded to that in one of my slides—that's lack of access to grocery stores, that's lack of access to playgrounds. And what do you sometimes have? You have higher levels of substance use, higher levels of gangs, and the like. Those things are actually correlated to higher levels of violence.

JD: This is Julia Silva with the Violence Prevention Office. The data that we have about child maltreatment and youth violence come from referrals and reports coming to Child Protective Services. Those are mostly from low-income families. If you look at the Department of Health and Human Services child maltreatment reports that they have every year, that's what we find there. Of course there are a lot of people that say, well, poor people report more, or the police or social services or the social workers or the school counselors—they have a way to know that their kids are acting out, and there is no other resource but referring them to this Child Protective Services for them to find something to do for these kids. Whereas, more affluent families, when their kids are acting out at school, they are referred to a psychologist, or to a treatment, or to medication. This is a socioeconomic issue that we deal with. To tell the truth, the data we have is collected mostly from low-income families—that's how we know. Also, because all the issues related to, and interventions that psychologists have done—if they focus on primary prevention, secondary prevention—they go to at-risk communities where we know the statistics are higher and the data we have about incidents are higher for communities at risk.

RF: I would argue again too, on the back of that, those same communities also lack resources. Those are communities that are also severely under-resourced at the financial capital and the social capital level.

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KKT: There were a number of questions that talked about psychologists and general public and how they can get involved in policy and advocating for policies around Head Start and a number of programs. There were dozens of questions in that area. So we've asked one of our colleagues to join us—Amalia Corby-Edwards is going to talk a little bit about APA and what APA does to lobby on these related issues, and also how you can get involved.

Amalia Corby-Edwards (ACE):

Sr. Legal and Federal Affairs Officer, APA Public Interest Government Relations Office

www.apa.org/about/gr/pi/

I'm just stepping into the call so I apologize if I repeat anything that's been said. Just to give you a quick overview of what we're doing in the APA Public Interest Government Relations Office. I work on children's issues, family issues, and my colleague, Roberta Downing, PhD who was not able join us, works on poverty issues.

Some of things I've been working on include supporting a home visiting coalition that's a broad based group of organizations that are supporting reauthorization of the home visiting program that program that was in the Affordable Care Act. The CCDBG Reauthorization, which hopefully passes later this Congress, that's the Child Care Dependent Block Grant, and that's something that we've asked people that are in our Federal Action Network, which included psychologists and other members to contact their members of Congress. And so we've gotten involved that way. A bill that we were supporting earlier this year, HR-4980, which I don't have in front of me—Strengthening Families and Preventing Sex Trafficking Act is the approximate name of it—supports transition for foster care youth. It's actually a fantastic bill that provides some funding for tracking of these youth, to avoid having these youth fall into the trap of being sex trafficked. There's also funding for transitioning youth out of their group home and out of foster care, so they can have a social security card, driver's license, and other documentation to help them transition into a normal adult life. Some of the things that Roberta's been working on that I'm a little less familiar with is that we did have a Congressional Briefing on the stigma against long-term unemployment and its psychological effects. APA also weighed into supporting raising minimum wage and to extend unemployment benefits, and we endorsed paid sick days legislation and family medical leave legislation.

KKT: Thank you so much Amalia. I am so sorry that we have come to the end of our time, and I want to be respectful of everyone's Friday afternoon. Unfortunately we were not able to even get to half of the questions. There are a number of great questions, and we will try to respond to that and make a Q&A available online. Thank you so much for participating. We will be sending out copies of the presentation as well as information for accessing this presentation online. Thank you again Dr. Marston and Dr. Flores. If you have a 10-second last word, you can say them now.

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RF: I just want to thank everybody who took their time out this afternoon to listen to this very important topic, and I look forward to all of the good work that you all will continue to do.

DM: I just wanted to say thank you as well, and I'm very happy to see all the interest in this topic and interest in moving forward and helping families in poverty.

KKT: Thank you.