Preventing Shaken Baby Syndrome/Abusive Head Trauma
Child Care Health Consultant Webinar Series

April Powell: Good afternoon. Welcome, and thank you for standing by. My name is April Powell, and I am the Program Manager for the National Center on Early Childhood Health and Wellness. And I'm pleased to welcome you all to today's webinar. Before we begin, I have just a few housekeeping items. First, all participants will be muted throughout the entire presentation portion of the webinar. There will be a slide presentation shown throughout the webinar system that only the speakers will be able to control. If you have a technical question during the webinar, please type it in the Q and A box on your left-hand side of your screen.

There'll be a lot to cover within the hour, but you can submit questions at any time by typing it in the chat box. Only the webinar staff will be able to see your question. Some we'll answer right away, but some we might not be able to answer, and we'll give you an email with the answer after the webinar. However, at the end of the presentation portion, there will be time for Q and A. So during the webinar, there will also be videos played. The sound will come through your computer speakers. If you're listening to the webinar by phone, you'll need to turn up your computer speakers to hear the sound of the videos. Before the close of business today, you'll get an email from us prompting you to take an online evaluation.

Only those who take the evaluation will get a certificate, and the certificate will be emailed to you in no less than 10 business days. This webinar is being recorded, and an archived version, along with the slides, will be available to you following the webinar. So for today, we have two expert speakers. First of all, we have Dr. Bob Sege, and we also have Kim Clear-Sandor. So now I'll turn it over to Kim.

Kimberly Clear-Sandor: Thank you, April. And welcome, everybody, to today's webinar. We're all very excited that you've chosen to spend an hour with us. We have a lot of folks registered, including some child care health consultants, Head Start health managers, and many other early care and education staff who are joining us to hear information about shaken baby syndrome, severe head trauma in early care and education programs. As April shared, my name is Kimberly Clear-Sandor, and I'm a Senior Training and Technical Assistance Associate with the National Center on Early Childhood Health and Wellness. We like to call the National Center NCECHW for short. For over 20 years, I've cared for children and families in underserved settings as a nurse and family nurse practitioner and with early care and education programs as a childcare health consultant. I'm passionate about leveraging my understanding of health, families, and early childhood to advance children's health and safety growth and development within education settings. In addition to my work at NCECHW, I'm also the executive director of the Connecticut Nurses Association and provide private health consultation and training to ECE programs. Today, we're so excited to have Dr. Robert Sege join us. Dr. Sege is the Chief Medical Officer and Director at the Medical Foundation at Health Resources in Action.

He has a special interest in clinical and translational research and is a senior fellow at the Center for the Study of Social Policy in Washington, DC. He's also a visiting scientist at the Harvard School of Public Health. He previously directed pediatric primary care divisions at Tufts and Boston Medical Center. Dr. Sege has published, spoken, and served as a media source on topics related to children's health. He is a member of the Board of Massachusetts Children's Trust and the board of directors of the Prevent Child Abuse America. He received a BS from Yale College, a PhD from MIT, an MD from Harvard Medical School, and completed his pediatric residency at Boston Children's Hospital. You can see why we're so

happy that he's here today to share his experience and knowledge with us. So over the past several years, there's been increasing recognition that shaking a young child can cause brain injuries. Shaken baby syndrome, or SBS, and abusive head trauma, or AHT, are forms of child abuse that occur when an infant is violently shaken by a much larger person, causing that brain to bounce inside the skull and resulting in brain damage and even death. It's a devastating form of child abuse, with 30 percent of all infants who are shaken die, and upwards of 80 percent who survive suffer permanent, lifelong abnormalities. It's very important that caregivers and those that support them are knowledgeable about SBS/AHT and preventative strategies. So it's our hope that through today's webinar, we're able to define abusive head trauma and help you recognize the signs and symptoms. We're able to explore what child care consultants can do to decrease the risk of abuse of head trauma. We hope to share the normal phase of development when infants cry.

And I put this picture on the screen intentionally to remind us all that they stop crying. But they do have periods of crying. And we have to identify strategies that families and caregivers can use to manage the stress and prevent abusive head trauma when babies do cry. So let's get started. Dr. Sege?

Dr. Robert Sege: So Kim, thank you so much for the kind introduction. And it's an absolute pleasure to be here and to be able talk with all of you, who are doing so much for so many children around the country. I'd like to start by just giving a brief clarification of the terms. So we use the term abusive head trauma. It's also known as shaken baby syndrome. According to the American Academy of Pediatrics, abusive head trauma is the broader term, and it's used to describe a constellation of symptoms that result from violent shaking, from shaking and impacting the head, or just blunt trauma to the head of an infant or a small child. Shaken baby syndrome is often used to describe abusive trauma that is inflicted on infants and young children. The injuries, as Kim mentioned, have the potential to result in death or permanent neurologic disability.

So another way to think about it is shaken baby syndrome is commonly used to describe one form, probably the most common form, of abusive head trauma. Throughout the webinar, we're going to highlight a few of the many national resources that provide information about abusive head trauma, with resources for caregivers, parents, and health professionals. The American Academy of Pediatrics and their HealthyChildren.org, as well as the National Center on Shaken Baby Syndrome, have a lot of information about these. You'll also see other organizations mentioned, www.dontshake.org, the PURPLE crying that we'll talk about. On the screen is the American Academy of Pediatrics' policy statement on abusive head trauma that talks about it, and also, All Babies Cry, which is a product of the Mass Children's Trust that provides tips and skills for parents.

Kimberly: Thank you, Dr. Sege. As April mentioned, at the end of the day, you will receive a post-webinar email with the evaluation. And there will also be the attached resource list. And all the resources that you see posted throughout the webinar will be on that resource list. So I know many of you may be trying to write quickly and take notes. I wanted you to know that, too, when you go on the All Babies Cry website, you do need to register. And you can register with the code that I posted in the Q and A section. It's capital ABCMA, as in Massachusetts, ABCMA, and you can use that on the All Babies Cry. Dr. Sege was able to get permission to share that with all of you. So that's an extra special treat so you can access those wonderful resources. I would like to get a feel for what are some of the activities that you're actually involved in and doing with your early care and education programs. So we have a poll up on the screen, and we're wondering what activities you participate in related to abusive head

trauma and shaken baby syndrome. Are you doing staff training? Are you working with your directors to review and write policies and procedures? That may even be included in some of the child abuse and maltreatment policies that you're doing. Maybe you're involved in training families or working with families. You might have the opportunity to observe infant caregivers and see how they are responding to crying infants and if you can offer any support or different ideas. You may have had the opportunity to do one-on-one discussions.

And you may also get to connect your programs and families to community resources. So thank you all. You're all so good at these polls. I'm going to go ahead and pop the screens out, the results, so we can all see what everyone's doing. And not surprising, the majority of you are doing a lot of training of staff. And it's so good to see that you're involved in the reviewing and writing of policies. And really, really great to see the second-most common thing you're doing is working with those families. And I think as Dr. Sege goes along today, it's going to be such an important piece of the work that we do to protect our infants, as well as even to see this connecting to community resources. Awesome. Thank you all for participating in that and jumping on it so quickly. So what is all the buzz about abusive head trauma? It's clear that it's a very important issue with severe outcomes.

And it's something that caregivers of young children should really know about. It's also come up a lot as the importance of it is echoed in the Final Child Care Rule and the Head Start Program Performance Standards that both require training on abusive head trauma and shaken baby syndrome. Both of these also point to Caring for Our Children Basics to encourage that we address abusive head trauma and shaken baby syndrome. So not only do we know it's an important issue, but it's also now part of the infrastructure that guides early care and education programs. So as a lot of you mentioned, you're doing a lot of training. You're doing a lot of training around abusive head trauma and shaken baby syndrome. I'm also wondering if you guys have -- so let me reword this question -- oh, there we go. Have you done any trainings on Caring for Our Children Basics? I'm curious to know whether or not you're using Caring for Our Children Basics and whether or not it's been something that you've been playing with. And I'm sorry for that little fumble there in the question. But we'll talk about what Caring for Our Basics is as we keep going. So the results, it's pretty close, though. We'll talk about Caring for Our Children Basics as we go. So I wanted to first pop up here the health and safety requirements that are addressed in the Final Child Care Rule and the Head Start Program Performance Standards that require health and safety training on the 10 key health and safety topics, such as first aid and CPR. You can see the full list of 10 on the screen. You see number six is the shaken baby, abusive head trauma, and child maltreatment. And you also notice number 10, which isn't highlighted, which talks about the recognition and reporting of child abuse and neglect. So those trainings are now going on, and it sounds like a lot of you are doing them. I just want to point out a little bit about Caring for Our Children Basics. So for those of you that are new to hearing about Caring for Our Children Basics, the Caring for Our Children Basics has about 70 standards or so, and they're health and safety standards that experts believe should be in place where children are cared for outside of their home.

The Caring for Our Children Basics should not be construed to represent all standards that would be need to be in place to achieve the highest quality of care and early learning. Rather, they really are a minimum set of voluntary standards that try to help align minimal health and safety standards across different systems. For example, the caregiver training requirements outlined in these standards are only to prevent harm to children and not to ensure their development and learning. The Caring for Our Children 3 database, which you see on the right-hand side, and you can access through that website,

represents the best evidence, expertise, and experience. And they are practices that should be followed in early care and education settings. Caring for Our Children has 686 standards, and many of them have been updated. So it's always best to go to the database online so that you can look into those standards. The idea is that once the basics are met, centers and family child care homes can continue to strengthen their health and safety practices by going to Caring for Our Children. So they can look at some different resources and rationale and dig a little bit deeper. I pulled out the standard in Basics in Caring for Our Children that addresses preventing and identifying shaken baby syndrome and abusive head trauma.

You can see the standard up on the screen. And the standard really recommends that all child care facilities have a policy and procedure to identify and prevent shaken baby and abusive head trauma. And the standard also recommends that staff that are in contact with children should receive training on the prevention, recognizing the signs and symptoms, having strategies for coping with a crying, fussing, or distraught child, and also, really an understanding of the brain development and vulnerabilities in infants and early childhood. And Dr. Sege is really going to talk about a lot of this today, which I hope you can then translate and use in the work that you're doing. As we think about the role of child care health consultants, and as you get ready to listen to Dr. Sege, I have just a little snapshot on the screen of some of the things that child care health consultants may be doing to support their program. And a lot of these actions usually fall into these different categories. They could be helping with the policies and procedures, the training, helping to communicate information to parents in the parent handbook, supporting directors and managers as they observe infant caregivers and support them in their coping activities, and so forth. So as we go through today, we'll think about some of those pieces. And with that, I'm going to turn it over to Dr. Sege to get us into the meat of this presentation about abusive head trauma.

Dr. Sege: Great, thanks so much. And I know this is a difficult topic, and I respect that. I'm going to try to go through both the science, the epidemiology, and a little bit about what we know about preventing it. But I think that the first thing to talk about is how frequent, actually, it is. So it's the most common cause of injury and death related to child abuse. And altogether, if you look at all the inflicted child injury deaths, which is child abuse deaths, 60 percent of them involve brain injury. About half of all the brain injuries in young children less than a year old are inflicted or abusive head trauma. And estimates are really hard to come by for a lot of technical reasons, but I would just say that the consensus is that every day, one or two US infants die of abusive head trauma and 10 to 20 are hospitalized. And we know that there have been awareness campaigns that have gone on. Prior to these, a study that was done in North Carolina showed that one in 20, 2.6 percent of North Carolina parents used shaking to discipline their children. So it's not a terribly uncommon practice, unfortunately.

The insight about what causes parents, usually, or caregivers to lose control and shake their baby really seems to be closely tied to crying. So if you look on the left, this is the frequency of crying. And babies can cry as much as five or six hours among the top third of babies. And even babies who are the easiest ones still cry for at least half an hour, peaking at around two months. So if you see that, that's a lot of crying. And I know that personally, my first baby came when I was already in pediatric training, and I was worried that if I heard babies cry all day, it wouldn't bother me when my own baby cried. I was so wrong. It really is very upsetting to a parent when the baby cries. And you can see that abusive head trauma peaks at about the same time as crying peaks. So about two to three months is where the peak number of injuries and deaths from abusive head trauma occur. And that data is from the CDC. So all this should make us consider all the many challenges that a caregiver faces when a new infant starts in

early care and education program, often right around the time when they're dealing with this peak of crying behavior. And of course, babies cry because they can, and it's a universal question, a universal problem. So if you want to answer these in the chat box. What are some of the caregiver challenges that you see with a newborn, a new infant enters a program? And I'll be so keeping my eye a little bit on the chat box as we go on.

Kimberly: I think it's such an interesting point to think about that, while that two months, and if you never really thought about infant crying, you just experienced it. It's interesting to see that there is a peak and there is a valley around the crying. But that two months really does line up, and a lot of folks do start to join or start at an early care and education program. And that's an opportunity. It creates an opportunity for the program, because they're working with a family to transition their child. So it's an interesting thing to note. So we are hearing that some of the challenges are getting the child to eat and drink from a bottle, especially when babies that are breastfed only, and they won't take the bottle, and they just want their mom. The teachers are getting -- [Inaudible] shares that the teachers don't understand the baby yet. They're just learning their routine and their cues. When are they hungry? When are they wet? So definitely a piece. The separation from mom, the challenges of ratios, the increase and stimulation for the infant can be a challenge in the classroom. There's a lot more going on in an early care and education setting than in the home. Infants that young may not be on a good schedule yet. They're just starting to try and get used to that. So a lot of good insight as to some of those challenges, and really highlights the need to strategically think about capturing that opportunity for caregivers preparing to receive a new infant into their classroom, as well as having that opportunity to engage parents about the crying behavior.

Dr. Sege: It's interesting. As I read through these, so many of them are also similar to what parents face at home. In particular, that the mom goes back to the workforce. There are all those bottle issues that come up. The baby crying, know what they need, all of those things. That's the frustration of a baby this age, 'cause they're not really good communicators, and they do cry a lot. One of the advantages for an early care and education setting is there are multiple other adults there. So you can sort of spell each other, and people who understand what you're going through and what the baby's going through are all there. That informal support is also super important. I'm going to skip now, and we talked sort of in general about shaken baby syndrome and what it is. But I want to just spend a minute or two and go through why babies are particularly vulnerable to this and what goes on. So first of all, infant brains are different than adult brains. They're more fragile. As we grow, we make more connections in our brain, and this connection is something called white matter. And there's a protein called myelin that insulates the neuron fibers so that the messages can travel quickly through our brains. But as a result of that not having happened yet, our brains as babies have a lot more water and a lot less structure. So they're a lot more prone to injury. There are probably babies somewhere in the world who've never had a little bump on the head, maybe. Contact injuries are common. We'll talk about injuries to the scalp, to the skull, and sometimes even bleeding inside the skull. But the thing that we're so concerned about is violent shaking. And as a doctor, you can see that, because there's bleeding behind the eyes. You can see on CT or MRI scans that there's bleeding inside the skull. And of course, our concern is brain damage. So to understand this, if you look at all the layers in the brain, the outside, of course, is the scalp. And then inside it, there's the skull, and there's a whole set of membranes. The dura is right under the skull, and there's a little bit of space there that is filled with veins. And then along the coating of the brain, there's another membrane called the arachnoid. So why does this matter? If you think about it,

getting a little bit of a hit, a baby bumping his head against a hardwood changing table is something. You can get a scalp bruise.

That's all outside the skull, doesn't cause any damage. And you can see in this picture, the blood just goes right along and above the outside of the skull, under the skin. Very common. Doesn't cause any long-term damage. Just makes the caregiver feel guilty. A little more pressure, and you can see what's called a subgaleal hemorrhage. And those go right next to the skull between the galea membrane and the skull. And those can look super ugly, because they can have a lot of blood, and consequently, swelling can spread there. Occasionally, you see those from difficult childbirths. But again, everything outside the skull, all these things heal completely. There's not a lot of pressure. There's usually one impact that causes it. Then a little stronger impact, you can cause a skull fracture. And the danger from a skull fracture really is if it breaks what's called the meningeal artery, which runs right under the skull. So again, the skull itself would heal completely. It's that blood that's a problem. And the reason for that is the blood gets caught beneath the skull, and it can depress what's called the dura, which is the membrane outside the skull, and the brain. And of course, if you look at this picture in the upper right, you can see that the brain is being squeezed, and you can see that in this CT scan. And obviously, pushing against the brain like that causes, potentially, brain damage through a variety of mechanisms that we'll talk about in a minute. And of course, the problem here is that the skull is hard. Even in a baby, it's relatively hard.

So there's no place for that to go. So if you have a big bruise on the outside of the skull, it doesn't matter. It really just goes out into the air. Inside the skull, which takes more force, it goes inside. In shaken baby syndrome or abusive head trauma that we worry about, when the brain bounces inside the skull, these veins can break. And when they break, what happens is that they can cause bleeding along the midline of the brain. You can see there's extra blood in that picture. And all of these things cause brain swelling. And so there's something called hypoxia-ischemia, which is a medical term. It basically means sort of suffocation. So when there's swelling inside the skull for any reason, as that pressure builds up, it can decrease the blood supply. The decreased blood supply, of course, causes less oxygen and nutrition to reach the brain cells.

Those brain cells are damaged, and part of the process of damage is they get more swelling. So you can see that infants in particular, all of us, but infants, because of all the things I talked about, are prone to this vicious cycle. So once it starts, that's what leads to brain damage or possibly death. So what does this look like for a baby? Whoops. [Inaudible] So within a few minutes to at most a few hours following an injury, the baby is likely to become tired and less responsive. Initially, they may be crying. There is often vomiting, 'cause as the pressure builds up, the balance center of the brain gets pressed on. That can cause vomiting. And of course, as all these things go on and this vicious cycle continues, the baby can go into a coma or even death. So we have these situations where a baby is dropped off at a childcare center after having been shaken at home, and the baby appears a little bit sick, a little bit unresponsive, but develops all these symptoms. Obviously something to worry about.

Kimberly: Dr. Sege.

Dr. Sege:Yes?

Kimberly: I'm sorry to interrupt. That was a lot of brain slides we went through right there. Dr. Sege: Yeah.

Kimberly: And I appreciate them, 'cause I think they really help us to see some of the common injuries that we might see, such as when a young infant that hits their head, and they get that immediate egg on the outside.

Dr. Sege: Right.

Kimberly: It's a little bit frightening to see. I don't know -- I'm going to try and see if I can scroll back to that picture real quick. Just going to go click, click, click. I'm sorry if I make you all have a headache there.

Dr. Sege: I think you want that one, right?

Kimberly: Yeah. So that's what, when they hit their head-- like my daughter was so colicky. And she would arch kind of violently sometimes. And there were a couple times she would hit her head on what might have been right above my arm. And immediately she would get that big, scary bulge. And so if that's what you're talking about in this picture, which is different than a blunt force trauma, which might cause that fracture and then the bleeding to happen on the inside, where the blue part.

Dr. Sege: Absolutely. So these are really common. And the one on the next slide are a little less common. But both of these, everything's outside the brain. No problem, except that you as a mother still remember. You remember for your whole life, right? And so I know one of my kids hit his head violently against this really nice, antique thing that we were using as a changing table at a hotel. I felt so bad. But doesn't cause any damage, because that's why we have a skull. It's to protect us. So there's that kind of thing, which is called blunt force trauma technically, but really it's normal wear and tear. Do you say that about a baby? [Laughter]

Kimberly: I think we would understand that.

Dr. Sege: Yeah. But that's really different than what you see here, if you look at this one. Whoops. If the computer will let me look at this one. In this one, you can see that there's pressure against the brain. The brain's being squoze. And these subdural hematomas could cause just a lot of blood on the brain. Those things are obviously very different, and they require more. And I'm going to go a little bit out of order, and if you don't mind, I'm going to skip to a video. And this video is part of the All Babies Cry series, and it's designed to show parents, and I think it would work really well for the child care providers as well, just to see what exactly happens inside the brain and what this is all about. So if you guys, I know some of you may have to turn on your computer audio a little bit to hear it. So once this video is loaded, you'll see the video from the All Babies Cry series. That will do it. And so I'm going to see if we can play it.

[Video clip begins]

Man: Especially when you don't know what's bugging him, it is really frustrating and you wish you could just do whatever it is that'll make him calm down.

Woman: I can totally see why somebody would just want their baby to stop. And they would just pick them up and go, oh, come on. Do this for me. Not realizing that they're doing harm to their baby.

Narrator: A tired, frustrated parent might think that the motion of shaking could be something to try. It's not. At birth, your baby's brain is still in the early stages of its development. Shaking would cause the

soft brain tissue to hit up against the much harder bone of the outer head, and permanent brain damage and disability could easily follow. Also, because a baby's neck is not very strong, you always want to support it like this when you hold her. Slow, supported, and gentle motion is what is safe for babies. Never shake your baby.

[End video clip]

Dr. Sege: Okay, so Kim, hopefully that helps in sort of taking some of the still slides I showed and demonstrating what really happens when a baby is shaken.

Kimberly: That's great.

Dr. Sege: Yep. And --

Kimberly: I know a lot of folks worry that-- holding a baby just that way is a great thing to show. And I think some people worry, how about if I bounce a baby on my knee? Is that okay? Is that gentle enough?

Dr. Sege: Yeah. And I think about it that if babies were that fragile, we wouldn't be here. So it requires a fair amount of force to cause all this damage. And if you think about it, all babies cry, and really a small percentage of them are shaken. So most of us most of the time manage to control our own emotions. So I just want throw really quickly, there's one other thing I want to tell you in this part before we go on to prevention, and that is that there are other associated injuries. And as a doctor, when we see these, we always look for head trauma or other problems in a baby this young. Babies under a year old generally don't get bruises. That's something that we need to think about, rib fractures, other fractures, and bleeding behind eye. And I think that what you might be most likely to see in early care would be bruising on any part of the body. It's not exactly abusive head trauma, but I mention it because it's common among babies who also are shaken. So we want to recognize abusive head trauma. These are the things you might see. Bruises in a young child under a year old, basically, before they're learning to cruise or walk, vomiting, lethargy, which means they are poorly responsive. They're sleepy.

You can't wake them up. Or children who have new seizures at this age. Those are the things which should raise your awareness about the possibility of that. And we talked a little bit about what triggers shaken baby syndrome or abusive head trauma. And the most commonly well-described trigger is crying, and we've talked about that. And The Period of PURPLE Crying is a program that's been developed a while ago now, and includes an 11-page handout, a 10-minute video in eight languages. And it talks about what to do when you're feeling frustrated and feeling frustrated and angry and tired. They're all part of being a parent. We don't really like to talk about it, 'cause babies are wonderful. They are truly a miracle. They are all of those things. But they're also difficult, particularly in this age before they can communicate. So with The Period of PURPLE Crying, what it talks about are three simple actions steps to try to carry the baby, walk them, talk to them. So give them some response when they're crying. If this isn't working, which sometimes it won't, it's okay to walk away, calm yourself, return to the infant when you're feeling better. So when that happens, just remember that no baby ever has died of crying. And it's very upsetting to the parent. It's something babies do. And Kim, I'm glad you mentioned you had a baby who cried a lot. Some babies just cry a lot. They can grow into fine children and adults. But at two months old, two months into being a parent, you can't be so sure that that phase is ever going to end. So you want to just be aware of that. It's a normal baby behavior. Being angry and

frustrated is a normal parent behavior. So walk away and just make sure to never shake or hurt your infant.

Kimberly: And these resources, the fact that they come in eight different languages is really awesome, because that's often such a challenge for programs working with families from diverse backgrounds. But thinking about these simple action steps, and thinking about doing training with staff and trying to help them recognize that a crying infant may create stress in them, and what are some things they can do as they're caring. The ratio of a caregiver to infant, they're caring for more than one. So they might have a couple criers in that room. So ensuring that those caregivers really have the capacity to recognize the crying and understand it's creating stress and have some of those strategies as well is a neat thing to think about including in procedures and staff training, and reminding caregivers when they're about to receive a new infant about some of the strategies that they can use. So thanks for sharing that.

Dr. Sege: Yeah. Yeah, anybody who's a caregiver who cares about the baby is going to be upset by all this crying. No way around that. So we talk about preventing abusive head trauma. These are the five strengthening family promotive/prevention factors. One is parental resilience, and resilience is simply the ability to bounce back from stress.

So obviously, one of the stressors is I'm sleepy. I haven't gotten a good night's sleep in months. My baby's crying, won't shut up. That might be stressful. The ability to bounce back from that stress. Parent knowledge of child development and parenting. So in this case, the simple knowledge that babies' peak crying is from two weeks to about two to three months of life, that it does get better, that it's a normal baby behavior. And as they learn to laugh and coo and make other noises, their need to use crying as a communication strategy goes away. So they still cry, but much less. We also know, particularly in this day and age, that families need food, shelter, those concrete supports, and the absence of those creates an enormous stress for families. We also know about social connections. So I talked a little bit about how early childhood educators, you have those social connections. There are other adults, usually, in that facility. A lot of the trauma happens when there isn't social connection, so if there's not another adult to turn to. One question that we try to ask parents early in life is who helps you with your baby, or who can you call in an emergency if you're all stressed out? 'Cause we know that social connection is super important. And the fifth preventive or promotive factor is a child's ability to make connections. And this develops as their communications develop. So again, in its very young infancy, it's not really well-developed yet.

Kimberly: So I'm wondering if we could just take a moment and share in the chat box if anyone's had the opportunity to work with families in their program, and what did they have the opportunity to work on with them? Have they been able to do any trainings or handouts that are able to support or promote any of these preventive factors with families? So if you have any ideas, we'd love to hear them in the chat box. And I know you can't see the chat box, but we're happy to share what you're putting in there with everybody that is online. So Gina is sharing that she's done some safe sleep training which included some information on how to calm the baby, which is great. Great to do that with the families. They're often given this information in so many different places, but the more times they can hear it, the better. Somebody shared that they used The Period of PURPLE Crying, Dr. Sege.

Dr. Sege: That's cool. That's nice.

Kimberly: Yeah. And safe sleep training with their families. Becky shared that she's used a shaken baby doll to show the impact when a baby is shaken. Another one has used the PURPLE strategy. Someone else shared that parents receive annual safe sleep. So that's a great opportunity with that safe sleep training to think about what can we share about abusive head trauma/shaken baby syndrome as well. Somebody shared that their staff is then introduced as a protective factor. And then someone else is giving out handouts when they visit families. So lots of great ideas.

Dr. Sege: Wow.

Kimberly: So thank you for sharing all that.

Dr. Sege: So I just want to share one other program with you, All Babies Crying. And my disclosure is I'm on the board of the Mass Children's Trust that has this program, and I also was involved in the initial project to develop it. And it's based on the five protective factors that I just mentioned. And we tried to take programs like PURPLE, other programs like it, and build a new approach that would incorporate these five family strengths. And also, really specifically, it's skill development. So what you need to do for stress reduction? And we want to make sure that we taught parents enough about infant behavior, like babies cry just 'cause they are, to remind parents their needs are as important. So if you think about parental resilience, and anyone who's had some amount of experience with parents know how frequent it is for parents to essentially sacrifice themselves and not take care of themselves during this period when the baby so young, just to take care of the baby. That that is sometimes, for some parents, counterproductive. That they should have permission to take care of themselves. Sometimes crying is not possible to console. That's okay. It doesn't mean you're a bad mom or a bad dad or a bad caregiver. It just means you have a baby who cries a lot. And we talked about this a little bit, but just to make sure that everyone understands that we know that new parenting is stressful. So many of our families are isolated.

They don't have anyone near them all the time that says, "Oh my god, I remember when I was a mom, or when you were a baby, how stressed out I was." So we want to encourage people to reach out for help and to give them some basic tools. So the next video I want to show is the one that's in the series. And again, you can download them. They're all independently available to look at. And as you watch this, it's about parental resilience. But I want you to watch. We've also included men or fathers, because we know that a lot of abusive head trauma is committed by fathers or a non-biological -- what do they call them -- men who live in the home along with the child's bio parent, usually in a relationship with the mom. So we want to make sure that, when we're doing abuse prevention, that the images on the screen include men and women. So it's going to show you -- this is a 41-second video. Just an example so you can see what kind of short videos there are that touch on these. [Video clip begins]

Man: He starts to ratchet up. You start to get tenser and start to get more anxious about how to fix it.

[Crying]

Narrator: Sometimes the best thing you can do for yourself and your baby is to put him safely in his crib and step away. Take a few minutes to yourself to regroup. [Crying] Man 2: But it's so difficult, you know? It really is.

Woman: You got to just learn how to just be able to put him down and walk away. It gives him a minute to get himself together, gives you a minute to get yourself together. And then you come back, and he's a little bit more calm, and try again.

[End video clip]

Dr. Sege: I think that this is what I want to cover about sort of the science of shaken baby, a few of the resources that are available to help with shaken baby syndrome and prevention. Getting understanding that baby crying is normal behavior. Adults who care for babies when they cry are stressed. That's a normal behavior. Boy, I would love to be able to fix either of those, but what we really have to focus on is how to take care of those feelings without hurting the baby. That's the first thing. And the second thing is that if you've seen an infant who has bruises, or who seems lethargic or out of it or unresponsive or is vomiting, you need to be concerned that they may have experienced abusive head trauma and initiate, maybe take them to the emergency room, or at least have someone else with medical training look at that baby. Because the progression, once the bleeding starts inside the skull, which I showed you, that progression of bleeding and swelling and hypoxia can be irreversible. And it doesn't always happen immediately after the baby experiences the trauma. It can take a few minutes or hours. So it's possible to see that. So those are the main points I want to cover today. And I wanted to open this up to discussion. I know there are 343 people on the line. You have a lot more experience in early childhood education than I do. So if you can use the chat box, or looks like there are already some questions that we might address.

Kimberly: 'Cause you know, Dr. Sege.

Dr. Sege: Yep?

Kimberly: Sorry, I didn't mean to cut you off there. I think what's so interesting about the prevention and the promotive factors with abusive head trauma and shaken baby syndrome, so much goes towards kind of giving parents and caregivers permission to feel stressed out, and then letting them know that it's okay, that crying is normal. Doesn't mean they're a bad caregiver and that they're not meeting their children's needs. And it may sound so simplistic, but caregivers put so much stress and pressure on themselves when they care for that infant that it may be something very hard to remember.

Dr. Sege: Yeah. And people who love these babies and know them, of course they get stressed out when they cry. And it's the sign of love, right? If you didn't care about the baby, then. And that's a bit of an irony of all this stuff that we're talking about, is that the stress comes from love that can cause huge damage. I just saw a question that popped up from Gina about the long-term effects from this. And so obviously, death is a long-term effect. And then there are other effects that can happen that we see frequently. Probably the most common would be some form of intellectual disability, that there is some nonspecific brain damage. There are other things. Seizures can happen. Blindness, and oddly enough, it's not blindness from the eye going bad. It's because the visual cortex part of the brain is subject to damage. Some forms of brain damage can recover. So children who've had abusive head trauma should be in early intervention. They should be in a stimulating environment to help their brains grow, because we know that brains are capable of enormous healing. So it is important to do the best we can. And if you believe the statistics like the ones that I showed you earlier from North Carolina, there are probably many more babies who were shaken and don't have actual symptoms that bring them to medical attention, but have some of the subtler brain problems.

Kimberly: Dr. Sege?

Dr. Sege: Go ahead.

Kimberly: I was just going to go on to the next question.

Dr. Sege: Sure. Go ahead.

Kimberly: So Shannon asked about how would you intervene if you saw this happening?

Dr. Sege: Well, if you actually see a baby shaken, then you can intervene by just yelling stop and taking the baby. I think that it's unlikely that you'll actually see that. That usually happens in privacy. And I think that what you're more likely to see is a family, a caregiver, who looks extremely stressed out, more than what is the average amount of stressed out for the parent of an infant. And particularly someone who's isolated, who doesn't seem to have a lot of resources, psychologically or otherwise. And so those are parents you may want to reach out to and see if there's someone who can help them, a family member or friend. One of the things I think is most effective is just giving young parents or parents of babies a chance to sleep, wash their hair, maybe take a shower, maybe do some shopping. So that personal outreach, I think, is something that you can do, maybe not yourself, but with the other parents or the other resources in the community.

Kimberly: And it's a good chance that if a baby, their crying is stressing out the caregivers in a program, that the family may be experiencing the same stress at home. So thinking about that, how to share that.

Dr. Sege: That's a really good point, 'cause we sort of skipped over that in that slide I showed you. There are babies who are called high criers, and they're going to cry at the daycare center. They're going to cry at home. So I think, Kim, that's a really good point, that if we see it or if you guys see it in a daycare center, you can be pretty sure that it's not just you, that the baby is just one of those babies who cries more than others. Maybe they'll talk more when they're 12. Who knows? [Laughter]

Kimberly: And then Maureen has a great question that says, "Parents may be able to walk away from a crying baby. But what can child minders in an early Head Start program do, 'cause they cannot break ratios?" And I think that is such an important point. And maybe that becomes one of those considerations as you create policies and procedures. And you think about a culture of safety in the program where everyone is thinking about children's safety, and staff have the permission to be able to call someone. Who do I call? Is there a director? Is there an education manager? Is there someone that can just sub out for you when you flip-flop places with? And ensuring that those infant caregivers have some sort of a plan so that they can address it may be something that helps them self think and work with a program to develop a plan The reality is we can't break those ratios, and we wouldn't want to do that. But we also know that coming up with a plan B when you have a baby crying that's really stressing people out, we do. Can we get some other help in there for that program? I'm sure some of you have some other ideas on that, too, so feel free to share.

Dr. Sege: I saw a couple of questions about infants' eyes and whether you can see. And actually, you can't. It's in the back of the eye. And so you need an ophthalmoscope -- when the doctor looks in your eye, it's an ophthalmoscope -- to look at the back of the eye. And even for me, and I'm pretty experienced, it can be tricky. So in a medical setting, we usually have an ophthalmologist. And sometimes we'll put eye drops in as well just to make the pupil a little bit bigger so you can see the back

of the eye better. So it's not something that you can see. And I put that slide in because if you read the newspapers about controversies about shaken baby syndrome, sometimes this issue of whether retinal bleeding, whether that's always caused by shaking or not, comes up. And it's almost always caused by shaking. It's a good sign. But I'm glad you asked. It's not the same as blood in the whites of the eyes, which we see for conjunctivitis or allergy or other similar, very benign, self-limited reasons. So the front of the eye is okay.

Kimberly: I just want to share that Michelle is a child care licensor in her state. And she shared that if providers called her and expressed the situation with a crying baby, that she would be happy to help them work on a plan for relieving and working on the stress of that. So maybe other licensors in your own states may be a wonderful resource for negotiating some sort of a plan that ensures that all children are safe. So thank you for sharing, Michelle.

Dr. Sege: And Jackie asked, "If they see a bump or bruise on the head, is it okay to reassure the parent that medical care is not necessary as long as no other symptoms are noted?" And I would agree with that with one major if. It's perfectly reasonable to ask what happened. And if a parent says, I was changing the baby, and she arched her head and flew her head back onto the changing table. I heard a big whomp. Baby cried. Something else that seems completely believable and there's a small bruise, then sure. But if they're vague about what happened, or nothing happened, it just popped out of thin air, that always gets my antenna going, because I think that those are situations where there may be much more going on than you're aware of. And that's something that I think if you have a child abuse consultant, you might want to talk with them. If not, just sort of think about as a staff whether that rises to the level where you need to report or suggest that the baby is getting medical attention to examine the rest of the baby. Because what we know is that in this age group, bruises are pretty rare. So we have a two-year-old and they don't have bruises, there's something terribly wrong with that child, 'cause they're supposed to be running around and tripping and falling and running into things. They always have bruises on their shins. But an infant at this age usually doesn't. So if they're totally innocent explanations, but the parents will, in almost all cases, know what happened.

Kimberly: I hope that was a helpful answer. That was a great answer, because as children come into a program, staff often do what we call a daily health check, where they observe the child and have some engagement with a parent about how the child is doing. And if they see anything, they will follow up with them. So that might be a moment where they notice something like that and need to follow up. I also encourage folks to take a look at their child abuse and maltreatment policies and procedures, as shaken baby syndrome, abusive head trauma, what are you supposed to do when you see something of concern, is usually laid out there. So that might be a place to go and look in your own program, or reflect on what's in those policies and maybe think about adding some of these pieces. Dr. Sege: And [Inaudible] asked a question, and Kim, I'm really interested in your answer to this, 'cause as a doctor, someone else who interacts with parents and their babies, this is always a tough question. She asked, "What about parents who don't share their stressors, yet they still need immediate support?" And I think it's really an important question. They all come to the child care because they trust you to take care of their most trusted thing in the world, the most important thing in the world to them. So there is that basis of trust. But what if it's not really there?

Kimberly: Yeah. And even, I think, something you said right at the beginning, Dr. Sege, that you have this miracle child, but the baby stresses you out. And you feel guilty for feeling that stress. So it may not

be something that they would immediately share with you. These families might be brand-new to your program that are feeling this way. So they haven't had an opportunity to develop trust in that relationship. And I think caregivers, child care staff, directors, these are usually so amazing in having supportive conversations about normal things that go on during children as they grow and develop. And even to have the opportunity to talk about how is your baby cry? Are they a crier a little bit, a lot? And kind of be able to address it like that all babies cry. Help me understand your baby. And use that opportunity to share a little bit about normal crying patterns. Because they might not feel able to come out and say it, but maybe you can find some creative ways to open that door, that give them permission that it's okay to feel that way, and it's okay to ask for help. But I don't know. Parents are a tough nut to crack sometimes. Dr. Sege: Yeah, and the other thing is that, for many parents, if you can sort of encourage them to get to know and help each other, 'cause they all have children the same age. This age group is tough, 'cause obviously they're new parents. But I think that there's a natural potential support group among parents who bring their children to the same center.

Kimberly: Well, thank you so much for all these great questions. I know there was a couple that we didn't get to, but I see that we are nearing the top of the hour. And I wanted to share a place where you can all connect with each other online to continue the conversation. We usually go into the MyPeers online community, and we can post some of these additional questions in there. So I wanted to put it up here for all of you. The MyPeers online community is a place where you can come and learn from each other, be able to ask each other questions, and do some peer-to-peer learning and exploring. And if you would like to register to be part of this community, you actually have to go into the community and fill out a form. And then you will get invited to join the community. So I have put that link up top on the screen so you can copy that down. And it may be a place that you can continue to share some of these questions. And I'm happy to follow up with Dr. Sege and get you some good answers. So Dr. Sege, any closing remarks?

Dr. Sege: I think the only thing I want to finally say is that child care itself is a well-known child abuse prevention thing, because the parents get a break. And you guys are professionals, want to be with the kids. And although from time to time, very rarely, bad things happen in child care, children are much safer there. And you're such an important support for families, the work you do. Even though you don't see it as child abuse prevention, as an outsider, among many of the things you do, you help prevent a lot of abuse from neglect. And it's such a privilege to get invited to speak with you.

Kimberly: Well, thank you so much for sharing that. And I tip my hat as well to all the child care providers that do such a great job with our children and families. Well, thank you so much for joining us all today. I have put on the screen our toll-free number, as well as our helpline email, which is health@ecetta.info. And I would just like to remind everybody that by the close of business today, you should receive an email that has a link to the evaluation as well as our resource document. And I, again, encourage you to consider joining the child care health consultant MyPeers online community to continue the conversation. I didn't put a teaser in here for our next upcoming child care health consultant webinar, which is coming on February 15 and will be on oral health. But that information will be shared soon with all of you so that you can register for that. And we look forward to seeing you then. So thank you, everybody, and have a great rest of the day.

[End video]