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PSYCHOLOGICAL  
ASSOCIATION

**Date: July 2021**

**From: Society of Pediatric Psychology, American Psychological Association Division 54**

**To: Pediatrician Colleagues and Other Pediatric Medical Providers**

**Re: Summary of Psychological Research Findings Relevant to Pediatric Care**

**Following is a summary of published research findings in the Society of Pediatric Psychology peer reviewed journals. We believe this information may be helpful to your own practice, with citations provided for further information. Please contact me with feedback or questions. [Sharon.Berry@ChildrensMN.org](mailto:Sharon.Berry@ChildrensMN.org)**

**Sharon Berry, PhD, LP, ABPP**

**What COVID-19 Teaches Us About Implicit Bias in Pediatric Health Care.**

**Mulchan, Siddika S., Wakefield, E. O., & Santos, Melissa. (2021). *Journal of Pediatric Psychology*, 46(2), 138–143. doi: 10.1093/jpepsy/jsaa131**

This topical review highlights the role of implicit bias in contributing to health disparities in pediatric care during the coronavirus disease 2019 (COVID-19) pandemic. While COVID-19's impact in youth is still emerging, previous research indicates pediatric provider implicit bias can negatively influence clinical decision-making and outcomes for marginalized youth and families, particularly under stressful conditions such as the COVID-19 pandemic. We describe the potential impact of implicit bias for marginalized pediatric populations in four key areas within the context of COVID-19. Based on our review, we recommend the following strategies to mitigate implicit bias in perpetuating health disparities in marginalized youth and families:

1. Individual Level – 1) Develop self-awareness about implicit biases and 2) Seek out strategies, such as perspective taking and emotional regulation training, to manage implicit biases that can negatively impact patient care
2. Institutional/Organizational Level – 1) Develop a culture of open communication about implicit bias, 2) Encourage patient advocacy, 3) Enhance utilization of community resources to reduce access barriers, and 4) Invest in quality improvement to provide feedback on clinical interactions with youth and family that may be susceptible to provider implicit bias
3. Educational Level – 1) Provide hospital-wide implicit bias training for all employees who provide direct patient care, 2) Integrate perspective taking and empathy building trainings in medical school and clinical rotations, and 3) Reinforce implicit bias training for trainees during supervision
4. Scientific/Research Level – 1) Use operationalized definitions and rigorously evaluate interventions for implicit bias, 2) Focus on implicit bias outcomes in pediatric



populations, 3) Incentivize research in this area through funding mechanisms within the context of COVID-19, and 4) Encourage the development of implicit bias interventions in health care through support from the National Institutes of Health and other research organizations specifically in pediatric populations

**Exposure to Tobacco Smoke and Temperament among U.S. Children 0-5 Years Old**  
Merianos, A. L., Nabors, L. A., Fiser, K. A., & Mahabee-Gittens, E. M. (2020). *Journal of Pediatric Psychology*, jsaa123. Advance online publication.  
<https://doi.org/10.1093/jpepsy/jsaa123>

It is well known that children exposed to secondhand smoke have increased risk of experiencing neurobehavioral health issues. Although rates of tobacco smoke exposure have been decreasing over time, rates are still unacceptably high at close to 40%. Unfortunately, children's homes remain the most prominent source of exposure for children of all ages, but especially among infants, toddlers, and preschoolers. Many parents who smoke tobacco products falsely believe they are protecting their child from secondhand smoke exposure if they smoke by a window or outside, and if they have home and car smoking bans. However, evidence shows that children who live in homes in which smoking bans are strictly enforced can still be exposed to aged secondhand smoke referred to as third hand smoke pollution via inhalation, ingestion, and dermal transfer long after smoking has ceased. Our observational study used National Survey of Children's Health 2017-2018 combined data to understand how overall tobacco smoke exposure, which includes exposure to both secondhand and third hand smoke, is related to early temperament behaviors among U.S. young children overall, and by two developmental age groups: 0-2-years and 3-5-years.

Compared to those living in smoke-free homes, 0-5-year-olds living in homes that allow indoor tobacco smoking are at increased odds of not always exhibiting behaviors that show positive temperament. Specifically, not always: being affectionate and tender, showing interest and curiosity, or smiling and laughing. When examining these behaviors by age groups, we also found both 0-2-year-olds and 3-5-year-olds who live with smokers who smoke inside the home were at increased risk of not always demonstrating positive temperament, with the older age group having more pronounced risk.

**Healthcare providers should universally screen for tobacco smoke exposure and parental tobacco use during all pediatric healthcare visits.** The Public Health Service-sponsored Clinical Practice Guideline for treating tobacco use and dependence includes strategies and recommendations to assist healthcare providers in delivering effective clinical interventions to reduce tobacco use and dependence. Briefly, parents who use tobacco, especially those who allow smoking in their homes, should be educated on how to implement voluntary smoke-free bans in their homes and cars. Further, since no level of tobacco smoke exposure is safe for children, parents need to be provided with tobacco cessation resources and referrals such as the Tobacco Quitline for free counseling and follow-up.

**We recommend that parents should also be given information on the risk of exposure on child temperament and recommendations on how to create positive parent-child**



**interactions for social and emotional development.** Ideas include praising positive child behaviors, such as listening and following instructions. Recommendations also include promoting positive parent-child interactions including having special time with the child where the focus is on interacting with the child, listening to the child, and following the child in play. This special time should occur regularly and can be as brief as 5-10 minutes per day to potentially make a difference. If the child is displaying negative behaviors, parents may offer choices the child can make or they should try to role model being positive and work to engage the child in a positive interaction and response cycle.

### **Role models or risk models: Short- and long-term effects of superhero media on young children's risk-taking behaviors.**

Morgan, C. H., Morrongiello, B. M., & Schwebel, D. C. (2021). *Journal of Pediatric Psychology*.

This study examined the influence of superhero media on children's risk-taking behaviors. Fifty-nine 5-year-old children were randomly assigned to view either a superhero television show or a non-superhero show and then engaged in three risk-taking measures. Parents reported on children's long-term exposure to superhero media and engagement with superheroes in their daily life via questionnaire.

The three risk-taking measures served as outcomes: 1) *Picture Sorting Task*, 10 illustrations of risky situations; children reported whether or not they would engage in the depicted behavior; 2) *Vignette Task*, opening sequences of 10 scenes describing common child activities; children chose which of three answer choices, ranging in riskiness, they would choose to complete the scene; 3) *Activity Room Task*, children were left to play independently for 5 minutes in a laboratory room arranged with a variety of items that appeared dangerous and might encourage risky play behaviors (children were monitored through a one-way mirror for safety).

#### **Key Findings:**

1. Superhero media exposure over time was significantly related to children's risk-taking behaviors in the laboratory.
2. Contrary to our hypotheses, there was no significant impact of immediate exposure to superhero media on children's risk-taking behaviors.
3. Daily engagement with superheroes had a small impact on children's risk-taking behaviors.

Our findings suggest that long-term exposure to superhero media can influence 5-year-olds' risk-taking, and more so than immediate exposure to a superhero television show or engagement with superheroes at home. American children are exposed to considerable amounts of media at a very young age, including exposure to superhero media, and that exposure can lead to risk-taking behavior. Such risk-taking increases risk for unintentional pediatric injury, the leading cause of mortality for American children in this age group.



**Early childhood sleep intervention in urban primary care: Caregiver and clinician perspectives**

Williamson, A. A., Milaniak, I., Watson, B., Cicalese, O., Fiks, A. G., Power, T. J., Barg, F. K., Beidas, R. S., Mindell, J. A., & Rendle, K. A. (2020). *Journal of Pediatric Psychology*, 45(8): 933-945. doi: 10.1093/jpepsy/jaa024.

*\*This article received the 2020 Diane J. Willis Award for Outstanding Article in the Journal of Pediatric Psychology, which identifies research with the potential to make an enduring impact on the field.*

Behavioral sleep problems such as insomnia (difficulty falling/staying asleep) and insufficient sleep are highly prevalent in early childhood, impacting 20-30% of toddlers and preschoolers. Despite a robust evidence base for treating these concerns, research on using these strategies with families of lower-SES backgrounds and in the primary care setting is limited. This limited research raises questions about whether sleep strategies require adaptation to better align with family and contextual characteristics. This qualitative study assessed caregiver and primary care clinician perspectives to inform adaptation and implementation of evidence-based behavioral sleep interventions in urban primary care and with families of predominantly lower-SES backgrounds. Semi-structured interviews were conducted with 23 caregivers (96% mothers; 83% Black; 65%  $\leq$  125% US poverty level) of 2-5-year-old children with behavioral sleep problems and with 22 urban primary care clinicians (physicians, nurse practitioners, social workers, and psychologists; 87% female; 73% White). Patterns of convergence and divergence in perspectives from each stakeholder group were examined.

**Key Findings:**

1. Caregivers and primary care clinicians agreed upon the importance of understanding and flexibly addressing social and environmental barriers to sleep intervention strategies, such as family overnight or shift work schedules and having multiple family members sharing beds or rooms.
2. Both stakeholder groups also identified the need for more sleep psychoeducation resources, endorsed a collaborative and empowering intervention approach, and suggested technology-enhanced intervention strategies (e.g., videos and informational graphics to accompany face-to-face meetings).
3. Caregivers described child characteristics, such as stubbornness or high energy levels, as being main contributors to the child's sleep problem, while clinicians described family characteristics, such as reduced limit-setting or adherence to sleep routines, as being the contributors to child sleep problems.
4. Whereas caregivers perceived very few barriers to engaging in a primary care-based sleep intervention, clinicians identified many barriers to family engagement, including work schedules, childcare demands, and transportation needs.



Findings indicate suggest that adaptations may be necessary for effective implementation of common early childhood behavioral sleep intervention strategies in primary care and with families of lower-SES backgrounds. Clinicians making sleep recommendations should assess caregivers' perceptions about contributors to the child's sleep problem and barriers to sleep strategies. This information can inform collaborative care and a flexible approach that prioritizes different aspects of sleep depending on the family's needs and context. For instance, as having an "early" (before 9:00 PM) child bedtime may not be possible due to family work schedules, clinicians could focus on problem-solving ways to support the consistent timing and sufficient duration of child sleep. Assessing caregivers' perceived barriers to sleep treatment in primary care, as well as their preferences around technology-enhanced approaches, may also enhance treatment engagement, delivery, and outcomes.

### **Accidental Injuries in Preschoolers: Are We Missing an Opportunity for Early Assessment and Intervention?**

Allan, C.A., DeShazer, M., Staggs, V.S., Nadler, C., Perez Crawford, T., Moody, S., & Chacko, A. (2021). *Journal of Pediatric Psychology*. Doi: 10.1093/jpepsy/jsab044

ADHD is associated with preventable pediatric injuries and early identification and treatment could help prevent subsequent injuries. The current study evaluated rates of accidental injury in preschool children with and without ADHD using a large pediatric hospital network dataset spanning more than 4 years of injury data. Children with ADHD averaged fewer injury visits at age 3 and 90% more visits at age 6. Among patients with an injury visit at age 3, children with ADHD had 6 times the probability of a subsequent visit at age 6. At age 3, children with ADHD were estimated to have 50% fewer injury visits than children without ADHD, but by age 6, children with ADHD had an estimated 74% *more* injury visits than children without ADHD. Risk for many injury types for children with ADHD exceeded that for patients without ADHD by at least 50%. Conclusion: Injury risk for children with ADHD is dynamic and grows over the preschool period. We recommend the following:

- 1) Injuries within the preschool period, particularly repeated injuries, may represent an important opportunity for ADHD screening, evaluation, and treatment.
- 2) Quality improvement initiatives targeting improved communication in the handoff from acute care settings to primary care may help link children to services that could reduce subsequent risk.
- 3) For parents of preschool children with ADHD, the risk of injury increases as children approach school entry compared to children without ADHD. Anticipatory guidance regarding injury prevention may be increasingly important between the ages of 4-6 years old for children with ADHD.
- 4) Timely referrals for Behavioral Parent Training for all children at-risk for ADHD could help parents improve monitoring, supervision, and limit-setting, critical for reducing risk of injury over time.