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Naima: Hello everyone and welcome to Stress, Depression, and Resilience: Ask The Expert webinar. I am Naima Cozier, the training team co-lead for the Healthy Start EPIC Center and will serve as today's moderator. We have approximately 60 minutes set aside for this webinar. There will be 20 to 30 minutes presentation time, and 40 minutes for questions and answers. Questions are to be submitted only via chat, which can be accessed in the bottom left corner of your screen. If we don't get to your question by the end of the webinar, we'll be sure to include them in the Frequently Asked document that will be available shortly after the webinar. The webinar is being recorded, and the recording, the transcript, the Frequently Asked Question document, as well as the slides will be posted to the EPIC Center website. Before I introduce today's presenter, I'd like to invite everyone to participate throughout the webinar. At any point, feel free to chat questions or comments in the bottom-left corner of your screen.

So now I'd like to introduce our speaker for today. A scholar, educator, and activist, Dr. Fleda Mask Jackson is president of Majaica, LLC, a national research firm and think tank. She is the leader of Save 100 Babies, a cross-sector network devoted to social determinants of health approach for reducing black infant mortality. She is also a university affiliate at Columbia University and visiting scholar in the Psychology Department at Spelman College. Dr. Jackson is the author of numerous peer-reviewed scientific articles, book chapters, and public presentations on her work examining life course racial gender stress, health and birth outcomes, community-based participatory research, and community engagement for transformative change. A graduate of Spelman College and the University of Illinois, she is a recipient of the Spelman College Alumna Achievement Award in Health and Science. In 2014, Dr. Jackson received the Maternal and Child Health Award for the Georgia Public Health Association. Without further ado, here is Dr. Fleda Mask Jackson.

Dr. Jackson: Hello everyone. It's good to be with you wherever you are. I'm here in Atlanta, Georgia, and I know you're in places elsewhere. So it is my pleasure today to share with you materials on stress, depression, and resilience. The objective for this webinar today is to introduce the psychological and physiological aspects of stress and depression for us to understand how stress and depression impact the emotional and physical health of women, particularly during pregnancy, and to become more aware of resilience among the women served by Healthy Start. So

stress is everywhere. We're at a time where we talk about stress even to young children talking about stress. But it's also a good time for us to really understand and act on what its impact can be on the health outcomes for the women served by Healthy Start. Too much stress over time can lead to depression. And both of those are bad for a woman becomes pregnant. Stress and depression during pregnancy place the mother and her baby in utero, as early as in utero, at risk for poor outcomes pre-term and low birthweight and chronic disease risk, such as hypertension, diabetes, and depression, and obesity throughout the life course. So it's really important that we have a handle on stress and to understand that it has short-term and long-term consequences for both mother and child. As I said before, we now are talking about stress in ways that we had not discussed it or recognized it in the past. I think one of the things is now that we're giving more attention to really, very serious stress, the cause of stress that's post-traumatic stress, for instance in the military and in places where individuals [inaudible 00:04:32] bombarded with so much stress. It has given us an opportunity to look at the life-course impact of stress and to understand that we must be more mindful of it and have solutions for how to address it.

But even if we have different kinds of stress, which I will talk about, there are some people, no matter what the stress they confront, press through, and their resilience helps their psychological, physiological, and emotional state. And so, as we talk about stress, we're increasingly examining resilience. What is it about those individuals who, despite being bombarded with so many ill effects, so many stresses in their life, so many things that are deleterious to their health, that they seem to be resilient and to pass through. So, as indicated in the introduction I will, at the end, talk a little bit about resilience.

So first, what is stress? Well, everybody has stress, and so what is stress? Stress is both the experiences and the reactions to threats, harms, and challenges. And by threats there may be things that are not actually the experience that we have at the time, but recognizing that there may be something that could inhibit what it is that we're trying to do, or trying to achieve, that may be a barrier, in terms of going forth, or may be an affront to who we are, is also stressful. Harm, something actually may cause harm to us, whether that be someone who is about to attack us, or something that is being said to us verbally, certainly can be quite stressful. And challenges, things that we're trying to do that we hope to do, it deals with our

expectations. All of us have expectations of something, a direction that we might want to take literally as we travel or a direction that we want to take in our lives. But what can be stressful is those challenges. So again, stress is the experience and the reaction to threats, harm, and challenges. And the responses to stress are both emotional and physiological. And those emotional and physiological responses to stress, they are the result of different kinds of stressors or stress that we talk about. And we talk about stress again both as the experience and as the actual response to it.

But there are different types of stressors, chronic stress, everyday stress. So we think about everyday stress as trying to get to work everyday on time or being in traffic for long periods of time, trying to manage all the things in our lives in an effective way, knowing that we're bombarded with so many demands on our lives. Acute stress, we talk about acute stress as major life episodes, such as experiencing the death of a loved one or having to move from one location to another, changing a job, things that may happen in our children's lives. And traumatic stress is when we talk about catastrophic experiences. Most often we think of catastrophic experiences in terms of man-made or natural disasters. And so these things happen. We think of them independently but actually, in many of our lives they're happening simultaneously. So we certainly will have the things that we have to experience daily, but then there are those major episodes, like maybe the death of a loved one that happen alongside those chronic stress. And unfortunately there are times when there is trauma that is added to that. Now, the other thing is when you have so much of this stress, we think of it as being toxic and toxic because it reaches a level that really perhaps is beyond our capacity to cope, which is what I will talk about next.

So as I've said, stress is a combination of the stresses, the threats, the harms, the challenges, and the responses to those experiences. So if we understand that it is both its combination, what is the healthy balance of this? We have, at one time, thought from a physiological standpoint that there was a threshold or a set point that we would go back to and it would be normalized. But now we think about it in terms of allostatic load, so that we reach a point where the stresses exceed our coping responses, our coping capacities, and so when we have this allostatic load, when it's out of balance, it creates a problem for us. So stressing is constant without relief, without ways to cope, and can have serious consequences on our

emotional and physical health. If we're out of equilibrium for a long time and it just continues to ratchet up, and there's really no way of ameliorating those stressors, it has terrible consequences for our individual health. And in the case of women who are carrying a child, it has consequences for them as well. So what we know is that stress is not only a risk for physiological responses but it's also a risk for psychosocial responses, including depression. And there's a difference between men and women, so there are gender differences in terms of what stress does to the body. Cortisol levels that can be released as part of the stress mechanism, we see that women are more likely to report being stressed first of all, to acknowledge being stressed, and when they're exposed to stress their body responses last longer than men. So the cortisol levels stay up longer. The other thing is that we know that women may in fact respond to stress in some other ways. We have thought [break in audio 00:11:15] flight or fight [break in audio 00:11:19] in terms of stress, so that there is a direct confrontation in terms of stress or a moving away [break in audio 00:11:29] that are released that are part of what women do in terms of caring for, or that are released when breastfeeding, are part of the stress response for women, which is quite different than for men.

Now the other thing is when we talk about stress and depression in women, there is an indication that one in five women develop depression in their lives, and that pregnancy is the time that someone women are particularly vulnerable, not only to depression and stress. Of course this is a time of uncertainty in the lives of women. What will be the demands? Do they have the resources to cope and care for their children? And when they reach a certain point, it certainly has a link and be a risk for depression in women.

The stress response begins in the brain. The [inaudible 00:12:30] releases a stress signal that is sent to the hypothalamus where hormones and body functions are regulated. The signal sent to the automatic nervous system is where the reaction can accelerate the heart rate, the heart beats faster, blood pressure rises, or slows down and returns to normal. We also know as part of this cascade of responses that ultimately there's a release of cortisol and if those cortisol levels remain too high, it creates all kinds of conditions that can lead to cardiovascular disease, hypertension, diabetes and contribute to obesity. So again, there's a second component of the physiological responses where the hypothalamus, the pituitary acts with release of cortisol that fall when the stress is eliminated, but remain high if the threat never

goes away. And unfortunately in the lives of too many women, the threat never goes away, it never goes away. There's never a time for the release. There's never enough things in their lives for the support that will help the mind as well as the body and as well as the psychosocial responses of a woman to return to some stage of normalcy, whatever normalcy may be given the conditions and the environment in which some of the women who we serve in Healthy Start experience. Too much stress over a period of time contributes to infections that can result in premature birth, and so we're not just talking about stress at one time, we're talking about the cumulative effects of stress. So stress has life-course consequences. Stressors that begin absolutely in utero that cause infants to be hypersensitive to stressors and therefore for them to now be vulnerable to certain conditions, infections, and other ways in which their bodies don't respond properly. And of course, if you have that in utero, coupled with what we call toxic stress in childhood, it creates all conditions that makes a child vulnerable for chronic conditions, as well as emotional responses, that are deleterious to the child. Again, increased cortisol that never subsides can lead to restricted growth in utero resulting in low birthweight.

Now, as I said, stress poses a risk for depression. And again women are at a higher risk for depression than men. And the depression, women are more prone to certainly something that can appear throughout the lifetime. Depression is a medical condition. I think that's important for us to convey that. Certainly mental health conditions carry certain stigma, which prevent individuals from receiving the care that they should receive. But depression is a medical condition that's connected to physiological reactions as well as emotional response to stress. And so, so often in the communities that we serve, there's a belief that depression has something to do with an individual's incapacity, or some shortcoming, or flaw in them individually. But depression really is a medical condition that is manifested in feeling sad or blue for a long period of time. So we all have periods of time where we certainly feel down about a situation, but when it is extended for weeks and weeks, it signals depression, and absolutely medical care should be provided. It may not only predict depression for that particular time in a woman's life, and of course we're talking about pregnancy, but it also may appear throughout a woman's life. So it's very important, during pregnancy and other times, that women be treated than respond to their depression. Because again, depression before pregnancy is problematic. Depression during pregnancy certainly has its issues,

and depression postpartum is not only a concern for the mother but the infant whom she now has to care for. The physiology of depression is there's also elevated cortisol, and there's abnormalities in the interaction of the neurotransmitters and hormones. One of the things that happens during depression is there's an irritability, loss of interest, and at the far level is suicide.

Depression during pregnancy can result in a woman having sadness and an inability to function that may be connected to the reaction to being pregnant, so at the time of pregnancy there are certainly women who may have had some misgivings about becoming a mother. And so now, here it is at pregnancy that this reality set in and certainly the stress of that can contribute to her becoming depressed during pregnancy. It affects a woman's ability to care for herself properly. So all of the things that a woman must do or should do in order to deliver a healthy baby can certainly be interrupted by depression. And it places a mother at a greater risk of having postpartum depression as I said and an inability for her to care for her child. So it can contribute to failure to thrive, in terms of the child or other needs, neglect of the child and so forth, which will certainly create a cascade of issues for mother and infant.

Developing resilience, and as I move to the latter part of my slides, there's no substitute for needing medical care for depression and extreme stress. And I think we have to underscore this, because I think sometimes as we listen to the advice for women to be resilient, it is a counter narrative to receiving the much needed medical care that women who are depressed, or in extreme forms of stress, getting the necessary health care that they need when they find themselves in this situation. Developing coping ways for yourself and your clients is important for really easing the burden that stress places on the body and mind. And so it's important for us to really advance ways that individuals can take care of themselves, both including medical care, but ways in which they can take care of themselves. So we're talking about resilience, because as I said earlier on, there are those individuals who seem to endure great stressors, but seem to be able to move forth or pass through. But their resilience is not something that's inherited. It's argued that there are various factors that contribute to resilience that allow some individuals to move to another state, even to the point of thriving. And thriving, I'd like to interject the notion of thriving, because thriving as part of this whole concept of resilience, means that individuals move beyond where they are to a

higher state of functioning. And so thriving is certainly, as we advance resilience in the women whom we serve, who are part of the Healthy Start community, thriving means that we move them even further, so that they are able to function at a higher level.

So, what is resilience? Resilience is adapting in the face of adversity, trauma, tragedy, and threats. All of these things of course, as I've indicated, are part of what comprises stress. Resilience is surviving, adapting and growing in the face of change, even in catastrophic incidents. This represents thriving, so that you really you grow, you go beyond, and thriving is the next thing, as I said. But it doesn't mean... and sometimes I think in our conversations about resilience, it's a notion that people are normalized [inaudible 00:21:33] circumstances. It means, yes, that people move beyond it, but it does not mean that it's acceptance of those things that are unfair or unjust. Stress, of course, is shaped by determinants of race, and gender, and class, and age, and region, and nativity, all of which is shaped by historical and contemporary factors. So if we go back to what stress it, stress is environmental, it comes from what our expectations are, of what our lives should be. It also comes from the way in which others or circumstances respond to us. And this is the result of both historical and contemporary factors. So resilience is also shaped by determinant factors as part of culture. So again, stress is shaped by all of those things, but the way that we are resilient is also shaped by those factors of gender, and race, and class, and age, and regions, and nativity. And what resilience does, out of these determinants, it emphasizes stress and assets, balances the idea of disparities and deficits. So in other words, we know there are disparities, there are differences, we know there are deficits but resilience really emphasizes the stress, and the assets, rather than the sole focus on the ideas of disparities and deficits.

So, what are some of the contributors to resilience? Caring relationships, we certainly have a body of literature that indicates that social support is a major intervention for stress and depression. Caring for the body. So one of the other things is that women, particularly during pregnancy and beyond or before pregnancy, since this is a life-course proposition, should have ways in which they learn how to take care of their bodies, nutrition, exercise, proper sleep, good healthcare, those relationships, all of those — a positive view of oneself. So this is based in terms of individual assets. What does one have that allows them to be able

to go through and overcome what the adversity of stress is? Recognizing their strengths and assets, setting goals, knowing one's personal history, community and group identity, and this is where history and culture come into play. Individuals from various groups who have understood the individual accomplishments of those within their communities, who have overcome adversity and been able to rise above it. And so it's important that the information about the personal family, community group and identity, and faith in religion. Faith in religion is also one of those factors in terms of resilience that allow individuals to move beyond themselves, to understand there is a higher calling, whatever their religious faith might be.

There are various resources that I would direct you toward in terms of... the American Psychological Association has references for how to deal with stress. There's a program out of Healthy Start called Belly Buddies, which I think promotes resilience and helping women to deal with their minds and their bodies, that they're prepared, and also to deal with the particular stressors, for instance, around racism and discrimination. "When the Bough Breaks," certainly gives a real indication of how racism as a stressor impacts the lives of African-American women, but also ends with some ways in which women have been resilient. The Center for Disease Control has various resources. And I would refer you to articles by myself and my colleagues showing how the stress of racism and sexism impacts pregnancy outcomes. And so this ends my talk, and I entertain any questions that you may have. Thank you.

Naima: Thank you Dr. Jackson. We have a couple of questions in the queue. The first question is, "Here in our county, it's not easy for women to access mental health services because of the taboo of mental illness. How can we encourage a woman to talk with her primary caregiver if mental health is needed in a rural area? Particularly because everyone may know your business."

Dr. Jackson: This is a really important question that all of us have to address. And I think one of the things that I've found in my work, which has fundamentally been around stress, I think stress is the easiest entryway for women to talk about mental health. Most individuals will acknowledge that they have experienced some form of stress. And I think if physicians would be more attuned to having a way both to assess stress in their clientele, and to have ways that are not threatening in terms of

the stigma that is attached to mental health, to deal with stress, I think we can open the avenue. For instance, in the state of New York, they are now doing universal... let me say this, there was a proposal that was presented to the legislation for universal depression screening. I think that's certainly one of the ways in which we could open that avenue and to see that as part of the battery of services that are offered by providers. But as you're saying, in a rural area, I think one of things that allows it are group sharing for women, if they will do that. But again, the issue of who knows your business and the stigma, is important. But stress generally is one that women and individuals will talk about. So I think having opportunities where individuals can come together and talk about those stressors that they have, to begin to advance where the medical professionals do screening for depression and stress, and to understand that they must provide services as part of integrative care. We have to move toward integrative care rather than the kind that's just strictly referral. And referral of course can work... strictly referral to have some ways in which women can have opportunity to address stress and to detect whether depression is part of what their issues are at the time of pregnancy.

Naima: Thank you Dr. Jackson. Our next question is, "How do different types of stress affect pregnancy?"

Dr. Jackson: One of the things I talked about, chronic stress and acute stress and traumatic stress, and there are lot of studies, good many studies, because of the way the data that we have that has certainly shown that those women who have numbers, you have so many acute stressors at the same time, that it contributes to poor pregnancy outcomes. But there are other studies that argue that it's not just the acute stress, those things that we think of as happening to disrupt, as a pattern interrupt in the life of a woman. So all of a sudden she finds herself having lost a loved one, or lost her job, or so forth. They would argue that it is these chronic stressors, accumulatively, that may be more pertinent to those poor birth outcomes. I would argue that it's a combination of all of them, and for some women living in the communities that they are, death can actually become chronic stressors because there's so much of it happening all the time, so it's not like a pattern interrupt, it almost becomes something that they may become numb to. Traumatic stress on the other hand, we know that women who lose everything, certainly they are vulnerable to any numbers of things that can impact their health, impact cardiovascular function, hypertension, and so forth. All of which leave her at risk

for adverse pregnancy outcomes and things that can happen to her during pregnancy, which puts her own health in jeopardy.

Naima: Thank you Dr. Jackson. Here's our next question, "You mentioned studies showing that elevated cortisol over a long period of time can lead to low birth weight, however, measuring cortisol levels is hard in a home-visiting program. Are there any studies that measured stress through a questionnaire, rather than the cortisol levels?"

Dr. Jackson: Actually, my own work dealing with contextualized stress does use a measurement we call "contextualized stress measure," that has found, as indicated the levels of stress within pregnant African-American women. And we have published that work to show that it is a predictor of depression in African-American women during pregnancy. Our next step in this is to really use it in a home visiting program as part of a way of giving the home visiting providers information and assessment so that they know what it is they may address for those women who are showing indication of depression and of stress during pregnancy. So yes, there are some measures, at least one measure that we are using now with women and hope to be able to employ it in a home-visiting program.

Naima: Thank you Dr. Jackson. And I just wanted to scroll through while we wait for a couple more questions, just so people see your slide of the articles you had mentioned.

Dr. Jackson: And I wanted to say, it's right here for resource, "Contextualized stress, global stress, and depression in well educated present African-American Women." And that was just done for well-educated but we are now using that measure in a public health setting.

Naima: Great. Please feel free to chat in additional questions. There aren't any additional ones in the queue right now. One just came in.

Dr. Jackson: I see one here.

Naima: Okay, "So in our program, here in Phoenix, Arizona, have developed a partnership with local therapists and we are actually required to transport the mom there for visits. And that increases the likelihood that mom will accept the help she needs at that time."

Dr. Jackson: This is great. This is great because we really are going to have to go beyond the referral. As one of the callers indicated, the stigma is really problematic around mental health. And so the women need that care at the time, they really do. And so that your program in Phoenix has a way in which you get the women to receive the needed care that they need, the care that they need at the time, that's excellent. Because we need more of that and how we integrate these services, I don't think we need anymore rationale for doing this. Depression levels are high, I suspect they're higher than we really know. But I just know that we don't have to wait until tragic incidents like in New York and other places where mothers have committed suicide or done harm to their children or any of those things to know that we really have to be very proactive in terms of meeting the emotional and mental health needs of women before, during, and after pregnancy.

Naima: Thank you Dr. Jackson. We have two folks that are very curious on how they can access the Contextualized Stress tool that you were mentioning. They wanted to know where it was published and also are you willing to share that tool with the Healthy Start community?

Dr. Jackson: I am willing to share the tool with the Healthy Start community, and that's why this is such an opportunity to talk with you about this, and if you will send me an email at fleda: F-L-E-D-A-M... fledamjackson@gmail.com, I will respond to your request.

Naima: And Ms. Fleda what we can also do at the EPIC Center is include that tool, if you're willing to share it, in the resources as well that we have online.

Dr. Jackson: We should discuss that.

Naima: Okay, great. And what I'll have is, we'll go ahead and... is it okay if we post your email address in the chat for folks to access?

Dr. Jackson: That's fine.

Naima: Okay, great, we'll do that. All right, we have another question here. It's asking, "How would you promote this information within the legislature to bring change?"

Dr. Jackson: One of the things that's exciting to me now is... there are a couple of things that are happening. And it means that we have to connect the dots in a way that I know Healthy Start communities have done for a long time. Healthy Start communities have, for a long time, built their programs around the social determinants model through their case management and the communities that they serve. And so it's now time for us to really bring this together legislatively and to make legislators understand that the concerns about wages, the issues around housing, the issues around racial profiling, are all threats to the birth of healthy babies. They are not separate issues and so, I think, one of the things from a legislative standpoint, that we have to always attach that to those issues that we know are vital for the communities that we serve. And it means our presence, so that it's not siloed that this is about mothers and babies, but that those issues that are about transportation. So for instance, one of the communities that I've worked in, a concern they had was that women were later and later coming for their prenatal visits. And part of the problem was there was no public transportation in the community. So the health centers have been part of that conversation about public transportation. So now public transportation has returned to that community because we can't expect women to make their appointments if there's no way for them to get there, if there's inadequate transportation. So I think legislatively, we have to yes, continue to advocate for those things that provide for the best healthcare for the women who we serve. That it provides for healthcare that happens pre-conceptually during pregnancy and afterwards, but also that we be part of the discussion part of the advocacy around those social determinant issues and continue to fight the causes that deal with racism and sexism that adversely impact the women whom we serve. We have the evidence, there's a large body of evidence, so we have to be part of that discussion, for us to make sure that all babies are born healthy.

Naima: And along those lines, our next question is, "What resources are available in terms of the research that has been published regarding racism and poor birth outcome?"

Dr. Jackson: Fortunately, there's a good body of work there. I would point you to the work by Diane Riley, I would point you to the work by Vijaya Hogan, I would point you to the work of Dominguez Parker [SP]. So there is a good deal of work that has been done in this arena, to show that the stress of racism, the stress of

sexism have deleterious effects on women's health. Because as a stressor, it certainly creates those physiological outcomes that I referenced before, as well as those emotional outcomes that ultimately pose risk for healthy birth outcome. So those are just some of the names but there is a — I would say — a good body of literature, and literature that doesn't talk necessarily just about racism, but literature on poverty, and poverty is also oftentimes tied to race, ethnicity, region, and so forth.

Naima: Okay. Dr. Mask Jackson, this is our next question, "What at a minimum do you think Healthy Start sites should be doing to change the conversation about stress and its impact on women and/or the community?"

Dr. Jackson: I think that Healthy Start sites do tremendous work, but I think Healthy Start sites have to really provide an avenue for women to have the exchange among themselves about the stressors that they have, for them to look at the assets that they have for relieving those stressors so that we don't remain in what are the deficits or what are the disparities, but to begin to have engagement processes that really elevate the assets that are among the women whom you serve and there are many. If you look at the lives of some of the women you can't even imagine how they really do function. But they function in communities, they have assets, some they may not even recognize. So I think that's one of the things. I think Healthy Start certainly are engaged in a variety of activities that could further advance nutrition, exercise, mindfulness as a technique, meditation, all of those things to incorporate. And so in the resources, for instance, Belly Buddies, which was a Healthy Start site out of Maryland, had a very well thought out way of dealing with the specific stressors that the women in their community engaged in, so they had a process which was facilitated, I believe, by a clinical social worker or someone who was clinically trained. As well as providing them ways to relieve the stress physically, but also the case management process. So I think there are things in Healthy Start, but to clearly articulate that stress is deleterious to the mother and to the child. That it has consequences that are harmful, short-term and long-term and that it cannot be ignored but it does have to be addressed. And I think Healthy Start is well positioned to do that. We're in a time now where the U.S. Army has recognized for the traumatic stress that soldiers have experienced, that it must address it. And I think that is going to open the avenue for this to be more widespread, and I can't think of any organization better able to organize its

resources, to say "yes, we're going to deal with this stress," and some of it we're already doing through the services that we now provide. I think Healthy Starts have to have a way in which they assess stress and to look very carefully at the depression data that they collect, that they respond to individually, but to look at that data that they already have around depression accurately and really get a better sense of what's the prevalence in the communities served by Healthy Start is.

Naima: Great. Our next question is, "What can we do to get our participants buy in the importance of identifying and reducing stress? For example, maybe incentives?"

Dr. Jackson: I don't know the population that this caller serves, so I don't know what their particular obstacles, you know your population better than anyone, I'm assured of that. But I honestly, in my interaction with women in several states, I've not seen there to be a prohibition about talking about stress. Depression, yes, but stress, not really. And so I think it's an opportunity to give women an opportunity to release and to understand that it's a normal part of life and for it to underscore, that while it has this emotional impact, that there are things that are going on in their bodies that they can't see. And so I think conveying that message in a way that is deliberate, that is explicit, that connects it to the desire to have healthy babies is the approach to be used. We talk about it in passing, but it really, really is. We have the scientific evidence. We know that there's a connection between stress, accumulative, unrelenting, unreleased, where there's no relief from the stress, we know that. And so now it's important for us to convey. I've seen in areas where they've done a media campaign to say to women, "Take care of yourself, relax, release, find ways that you calm down, that this is very important for you." And so I think those are the ways... again incentives, that I think, will depend on your community and how well you know your community. I don't think this is something that you have to bring women to do. I think it's something that... to heighten awareness of it is the best approach to take.

Naima: Okay, thank you Dr. Jackson. Our next, and it looks like one of our last questions, is "How important are home visits in reference to assisting participants with stress reduction?"

Dr. Jackson: I really think the home visitation model is a great model. And there's a model out of Cleveland, I believe it is, that home visitation is dealing with depression under close supervision. And I think the same thing could be done for stress. They are two different things but they really operate together. And I think having a way in which women might, as part of the home visitations, learning how to breathe, just take a breath. Learning techniques for mindfulness, those things. So I think stress-reduction techniques could certainly fit well as part of the home visitation model. Because home visitation of course where there's case management objectives, see those things, those instrumental needs that a woman may have for herself and her family, and can do the referrals and those other things. But for her to have the right mindset to do that, you have to deal with the stress. And of course if there's depression, the support for the clinical care can be provided as part of home visitation. So I do really see stress reduction activities as perhaps something that could be included in the home visitation, yes.

Naima: Excellent, and so we do have another question that was just submitted, "Is there certain language that you would use other than "stress," when developing a group. For example, a healthy relationship?"

Dr. Jackson: I like that healthy relationship. I still don't think that stress carries the same stigma as depression. But it might be for some communities this high idea... so there might be other terms that would be more culturally appropriate for the communities that you serve. But I do like that appreciative term of healthy relationships. So appreciative moves us to the language of destination. So if there's a destination that you want your constituents to reach for, then certainly starting out with stress might not be it, there be what the destination language. And it seems to me that what you have offered in terms of healthy relationship is one of those appreciative terms that moves us to the destination. And if that's the approach, I think that's perfectly fine to approach it that way. I just don't see the same stigma with stress. But perhaps it does develop anxiety in your population that prohibits individuals from moving to where they want to get to.

Naima: Okay. And our next question is, "Can you speak more about stress assessment tools? We have tools that assess depression, but we're looking for additional tools for stress."

Dr. Jackson: There are some well-established tools, Cohen Stress tools is one that's well-established. And there are some others that are... and if you send me an email, I can perhaps point you to some, but there are some that are well established, validated, reliable tools, that give you indications of generalized stress that have been around for some time. And Cohen is the one that I have used in my work, along with my own tool which is the Jackson, Hogue, Phillips contextualized stress measure.

Naima: All right. Well, that is all the questions that we've received so far. I do want to say just in case there's another question that's going to come through the queue, is that we do plan to have Dr. Fleda Mask Jackson back. We had had a couple of discussions of doing a series of these 'Ask the Expert' webinars, so we'll definitely have Dr. Jackson back. And we also talked about potentially also bringing this topic back up under the category of webinar of 'Hear from Your Peers,' so potentially having some Healthy Start grantees that are actually using some of these different screening tools and an opportunity to talk about some of their strategies in order to counter stress and depression. While I just mentioned that there was another question that just came in, they just wanted to again get clarification on the stress measure you just mentioned Dr. Jackson, what was the tool you just mentioned?

Dr. Jackson: I mentioned Cohen, but I also mentioned what is called the Jackson, Hogue, Phillips contextualized stress measure. You can send me an email and then I can send them the reference, or we can do it through JSI, for the actual measure itself, okay?

Naima: Okay. So with that, we'll go ahead and before we end, we just wanted folks to mark your calendars for some upcoming webinars for March. And on March 10, 3 to 4 P.M. Eastern there will be an 'Ask the Expert' webinar on preconception. On March 12, there will be a 'Hear from Your Peer' webinar on recruitment and retention. And just as a reminder as I stated in the beginning of the webinar, the transcript, recording, Frequently Asked Question document, and slides will all be posted on the EPIC Center website. You can also access additional resources in the Grantee Forum for the website as well. So this concludes our webinar for today. We'd like to thank you for your participation. We also look forward for you joining

us in future webinars and stay tuned for additional webinars from Dr. Fleda Mask Jackson.

Dr. Jackson: And I'd also like to say something further in terms of your training, there's going to be, through the National Healthy Start Association, a toolkit that will be posted in the months ahead which will go into greater detail than this period of time that we had allowed. So that will be coming up in the near future.

Naima: Excellent. So Dr. Jackson, just keep us posted and we can also post announcements of that toolkit when it's ready in the EPIC Center's News Alert, as well as on the website.

Dr. Jackson: All right.

Naima: All right, so with that we'll go ahead and close and we hope to see you soon on future webinars.

Dr. Jackson: Thank you.