ICF CWIG Webinar

Getting On the Right PATH: Attachment & Trauma Healing

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Julie Beem: Should we start full screen or start slides up? What's easier? Full screen so that they can see us?

Elizabeth Kramer: Yeah, why don't we do that? So, Julie, are you sharing your screen because I don't see the slides?

Julie Beem: Mm-mm. I am not, so that's why I'm asking you.

Elizabeth Kramer: Oh, I see what you're saying.

Julie Beem: Should we start with the slides up?

Elizabeth Kramer: Yeah, why don't we do that? They should still see us on the right-hand side. Perfect.

Julie Beem: Nope. That's not where I wanted to be. What's wrong...

Elizabeth Kramer: OK. Hello. And thank you for joining us. Today's webinar is brought to you by Child Welfare Information Gateway Administration for Children and Families with the United States Department of Health and Human Services. My name is Elizabeth Kramer, and I'm the senior manager for Knowledge Transfer and Information Management at Child Welfare Information Gateway. This webinar is one of several that we are offering virtually to help ensure that critical information is shared with professionals and families during the covid-19 pandemic, when we are

prevented from gathering in person and challenged to continue to work with children and families in new and innovative ways.

Today's presentation was originally scheduled as a breakout session for the National Foster Parents Association's annual conference. Just a few notes: we are recording today's webinar, and we'll be making this recording available on the National Foster Parent Association website, Training section. All of our participant phone lines are muted at this time, and we ask that you submit questions in the Q&A box. We will answer questions at the end of the presentation. At the end of the webinar, you also will receive a link to a short survey. We ask that you please provide us with your feedback on this webinar. So now I'm really excited to introduce our session today, "Getting on the Right PATH: Attachment & Trauma Healing."

Our speakers today are Julie Beem and Ginger Healy of the Attachment & Trauma Network, where Julie is the executive director and Ginger is the program director. And so now, Ginger and Julie, I turn it over to you.

Julie Beem: Thank you, Elizabeth, so much. Thanks for having us. We're really excited to be able to present this in this environment when we can't be in person, to meet folks that would have normally been at the conference. And, hopefully, that allows some folks that maybe weren't going to be able to travel to get this information as well. As Elizabeth said, I'm Julie Beem. I'm the executive director of the Attachment & Trauma Network, which is a nonprofit that is now in its 25th year.

And we focus exclusively on trauma-informed education strategies, practices, information, and support for parents, for educators, and for community leaders. And we've been doing the parenting program for the longest, and Ginger can tell you a little bit about that along with her introduction.

I personally have been the executive director for--this is my 11th year. Oh, my goodness.

And I am an adoptive mom and a stepmom and a biological mom and also now a grandmother, which is the best title ever, and have lived the life of parenting children who've been impacted by trauma. So, Ginger, would you tell everybody a little bit about yourself?

Ginger Healy: Well, I am so excited to be here today. I'm Ginger Healy, and I'm a mental health therapist. I'm the parenting director for the Attachment & Trauma Network. But most importantly, I'm a mom to 4 kids, and I have a son that was adopted.

If I tried to do the math, I'd get it wrong, but 18 years ago or so, when we adopted our son and he came to us with a trauma history, and so I learned a lot of hands-on experience through the years and then along with my career. So I love what I do and am really happy to be here and talk about our PATH parenting program promoting attachment & trauma healing. We have a lot of things that we do to support parents and provide advocacy and education support and resources. So I hope you'll all reach out to us. We have free membership for parents and caregivers that we just would love for you to all join.

Julie Beem: Awesome. So let's get started. We're really focusing today's presentation on foster parents directly. Obviously, this will resonate with child and welfare folks, social workers, adoption workers, other people who have worked with the population of foster and adoptive families.

But we really are speaking, even regardless of our professional backgrounds, in more of a parent-to-parent kind of way because that's how ATN focuses our work. And that's to start by talking about how parenting a child as a foster parent or parenting an adoptive child is different. What makes them different?

Oops. Helps if I know how to work the screen. Here we go.

Our children come into our home who have a history. Those of us who also have biological children know that children born into our families come with very little history. They're brand-new, so to speak. But the children who come into our homes--in a foster placement or in an adoptive situation--bring with them their history, and that history almost always includes loss, grief, complex family relationships, and it could contain cultural differences, racial differences. And at ATN, we have come to realize that a significant majority, if not all of our children, who come to us with those histories also come with a certain level of trauma. So what is trauma?

Ginger Healy: Our focus here at the Attachment & Trauma Network is early childhood trauma and the attachment difficulties that often arise and accompany it. But we like to focus on relationship and how that can really help and heal early childhood trauma.

And the definition that we really love comes from Dr. Bruce Perry at the Child Trauma Academy. Trauma is a psychologically distressing event that is outside the range of human experience. And trauma often involves intense fear, terror...helplessness. So I think the thing that we like to really point out here is that helplessness. You know, we cannot say with 100% accuracy that anyone--any child who has, for example, been in an orphanage for a year or has been sexually abused is going to be traumatized. It's different for everyone. There are things to consider, such as what was the impact? How long did the event occur? You know, what skills and age was that child? Many, many things.

But the reverse is true, too. We don't pick our traumas. What may have been traumatizing to me may not be to someone else. And when you consider a very young child who may not have the verbal skills or the coping skills or the support network, it's going to, you know, impact every

person differently. So it just depends on a lot of things. And that's what kind of leads us to talk about resilience.

Resilience is the ability to overcome hardships. We talk about being able to spring forward, and we also talk about navigating successfully through changing environments. And especially as we kind of go through this pandemic, I bet you're hearing that word resilience more and more--that we need it, that we want it. And we like to talk about, how do we build that? Because it's not necessarily something that you're born with. We all know that a baby is not born with the ability to pick up themselves by their bootstraps, right? A baby is born completely totally dependent on the adults that they're surrounded by to take care of them. So we have to build that resilience. So let's talk about how we do that.

And I absolutely love this punch line that we're going to give you, because it brings so much hope. And Dr. Jack Shonoff from Harvard Center for the Developing Child. And as an aside, I hope that you will take the time to go to the website for Harvard Center for the Developing Child because they have some absolutely fantastic education and resources that everybody can benefit from. But Dr. Shonoff-- [audio cuts out]

Julie Beem: Oops.

Ginger Healy: I apologize. Dr. Shonoff tells us that the single most common factor for children to develop real resilience is at least one stable and committed relationship with a supportive parent, caregiver, and other adult. And I don't know about you, but that gives so much hope. Sometimes it makes us feel a little overwhelmed, puts a lot of pressure on some of us. I don't want you to feel pressure. I don't want you to feel overwhelmed. I want you to know that even being here today and listening to this means that you're on that path and that you care and that you are seeking out information and help to help build resilience. And for

many, it's not just that one. It only takes that one, but if you think about people that you know who have come from hard places, any rags to riches story, if you peel back the layers of that story, you typically will find who in their life poured into them and made a difference and was stable and committed and filled them with that resilience that gave them the ability to meet their potential and keep moving forward.

So we're going to keep continuing to talk about this throughout, but we always really start with talking about--attachment because we, as humans, are wired for connection. We are born for that. And, you know, let me first say that, yes, attachment disorders are a real thing, but the good news there is that they are rare. Attachment difficulties, attachment problems, those are much more common. But what we know is that humans need to connect. We come wired to connect. So we like to talk about that attachment cycle. It's really important to go over what that means. And I know you all know this, but it really helps to kind of tie it all together. So baby comes into the world completely, totally defenseless, dependent on whoever is there to care for them. Baby has a need, baby cries. And then that need is met by a caregiver. And that cycle happens over and over again, and then trust begins to develop, and the baby starts to realize, "If I make my needs known, my needs are met, and this person will meet my needs." And when we do that over and over again, that is how that healthy attachment builds. So that is why the reverse-you know, when a baby cries and for whatever reason, the person that is supposed to meet their needs doesn't respond, can't respond, is unable to respond. You know, for whatever reason, that response is not met, then what happens is that when that need is not met, then mistrust develops. And that really results in a shifting of that child's self-view and world view. When a child's needs are met over and over, they think, "I matter. I'm important. I'm valued. I have a purpose."

And then, of course, then the reverse is true. They start to feel the opposite when their needs are not met. "I don't matter. I'm worthless. I can only depend on myself." And it starts to feel very unsafe for that child, very unpredictable and scary, and mistrust develops. And so that's when we start to see attachment difficulties arise and leading to many challenges. Anything else there, Julie?

Julie Beem: I don't think so, except maybe to point out that, again, the vast majority of the children who come into our care as foster parents have had enough attachment disruptions, as the professionals would call it, to have some skewed views about the world and about themselves. And they don't necessarily articulate that. They don't say it because--it's their view. It's the way that their early beginnings have ingrained who they are and how they fit in the world. So that presents a real challenge to us because those of us who didn't have attachment difficulties as children ourselves have a really hard time understanding that a lot of times.

The other point about attachment—and lots of people say to us, "Why are you the Attachment & Trauma Network?" Well, we view that attachment, that stable relationship, is the antidote to the trauma that our children have experienced, but also we have to understand what good, healthy attachment does. It builds that emotional relationship that Ginger was just talking about in the world view.

But the other thing it does that is equally important, and often we don't think about it, is that it builds our ability to calm down, our ability to regulate ourselves. And if you're parenting children who seem to be--oh, there's all kinds of words for it--out of control, dysregulated, losing their cookies all the time, melting down, having giant rages and tantrums like you've never seen before--the language would be that they're dysregulated.

And the way that infants learn to be regulated is by borrowing that regulation from their caregiver. The caregiver comes and calms them down. We know that about infants. We pick them up when they're crying, we bounce them around, we do all kinds of things to comfort them. But their brains learn to self-regulate from that repetition. So a lot of times, at least for me when my children were losing it big-time--and I learned this about their early beginnings and their brains--it made a lot of sense for me to remind myself that this isn't a personal attack on what just happened in our household. This is their inability to cope because their brain hasn't learned that yet. So that leads us to start talking about a little bit of brain science, which can be scary if you're afraid of learning a little bit of brain science, but I got to tell you, first of all, I'm a super brain geek, so I love this section of the slides, but I also want it to be something that is simple and memorable for us as parents. You don't have to have a Ph.D. in neuropsychology to get this. In fact, you probably already know it. So we're just going to point it out to you here. These are what we call our 4 brain basics that parents should know.

Number one, your brain develops from the bottom up and the inside out. If you're a parent, you already know this because children are not born able to walk and talk, right, in part because their bodies can't do those things, but mostly because their brains can't do those things. They haven't developed theirs. So this little baby banker that's over here on the far left of your screen, he can't exist. He can't amortize loans, he can't serve you, you know, if you need something at the bank because he doesn't know the math yet, and he won't until his brain is ready for that. It has to develop from the bottom up and the inside out. The same is true for our children emotionally. And the interesting thing is that it isn't necessarily tied to their age, to their chronological age. So if you have a child who's 10 and is behaving emotionally as a 3 year old, well, guess what their brain is

ready for. Three-year-old emotions because that's really where they are developmentally. So it's good to remember that brain basic, and we kind of already get it.

So brain basic number two--use it or lose it. Just like the rest of our bodies, our brain gets stronger in the areas that we use, and if we don't use them, we lose them. So, you know, if I went to the gym and I worked out my legs all the time and I never worked out my arms, my arms wouldn't build any muscle, but my legs would get really strong. So how does that impact brains? Well, if you're thinking about it in terms of our children's brains and whatever you know about the children in your care's history before they got to you, think about what parts of their brain would be used. It's likely that if they came from a situation where they were in a lot of danger or they were witnessing somebody else being in danger or there were--other dangerous things happening, scary things happening in their world, that the part of their brain that contains their fight, flight, and freeze, the part that is called the limbic system, if you want the technical term, would be activated over and over and over again. So guess what happens to it. It gets big and strong, right, because they're using it all the time. Now, the other parts of the brain--the parts within the limbic system that help to calm it down and the other parts of the brain that help to self-soothe and regulate the child's brain may not have gotten the same workout, right? Because we just talked about that cycle, about them not being able to actually calm down and actually self-regulate because they didn't have that regulatory on the top of them. So that's not as big and strong. In fact, there's a picture here of some pruners pruning off a branch. And that's to remind me to tell you that there's actually processes in the brain called pruning. So if you don't use something for, you know, a particular amount of time, your brain prunes away--not physically prunes away your pieces of your brain but prunes away the synapse connections that are there to make your brain more efficient. Your brain is all the time, it's growing and changing, even our brains as adults,

although not as fast as it does as children. It's constantly trying to find ways to work more efficiently. So if you don't use it, you actually are going to lose it and have to build a new pathway, you know, to create something. That's why some of us, like me, who don't exercise very much, find it really hard to start an exercise routine. We have to be very purposeful and very intentional and very repetitive for ourselves to get that habit. Habits have to be taught to ourselves over and over and over and over again for our brains to just start to do them. That's just the way they work. So the same thing for our children. If the children didn't, if their brains didn't learn something--and we're talking by learning, we're talking about emotional development as much as we're talking about math and, you know, academic subjects--if they didn't learn it, you know, it's gonna take a while developmentally to put that back, but it's not impossible.

So this is the third tenet that kind of drives that home. What fires together wires together. Because our brains are like an incredible superhuman--supercomputer-type situation, the things that we do over and over and over again and the things that we think and we feel over and over again start to get wired together.

Now, most of you probably, that I'm talking to, probably know how to drive a car. So this is a good example of how this works, right? So if you know how to drive a car, and now not everybody's likely to need to go to work like we used to, but you can remember back to every day, you got in the car and you went to work somehow. So you got in the car, and chances were that you were out of your neighborhood or onto the main street or halfway to work before you even gave any kind of real thought--your frontal part of your brain's thought--to driving, you know, unless somebody cut you off in traffic or unless there was something out of the ordinary. You got in the car, backed out of your driveway--hopefully, you put your seatbelt on first, adjusted your mirror maybe--backed out of the driveway, headed out of where you live, got on the main

street probably without thinking about those steps. How could you do that? I mean, how could your brain do that without you thinking about that? When you were 16, you thought very distinctly about every single step. But you've done it every day since you were 16 over and over and over again. And now your brain has a sequence that is wired together in your brain that if nothing unusual happens in that sequence, you're not cognitively--your thinking part of the brain isn't processing. The same is true for all kinds of things that we do.

I, for one, have a hard time remembering whether I brush my teeth at night or not, so I actually have been known to go over and feel my toothbrush to see if it's wet, because I'm thinking about the next day or maybe I've had a fight with my husband--or there was maybe a gazillion other things going on in my head--preparing for bedtime or assessing my day--and I just by, almost rote, brush my teeth, because it's become that much of a wired-in situation.

So think about what could be wired in to the children that we care for. What could be wired in emotionally? In a lot of cases, it is chaos that's wired in emotionally, which is why--and this is so common for a lot of our families were like, "We don't know what happened. The child just went from zero to 60 emotionally--" [Snaps fingers] "like that. What happened? We don't understand why they got so upset" over a TV show, a sound, a smell, a comment, whatever it was.

Something that seemed really benign, something that seemed not to have anything to do with anything to us, but it somehow was a trigger, and it sent them into this mood or situation or escalation that we don't understand. But it's because something's wired together the same way you can actually wire calm into your brain. But, again, you have to be purposeful

about it and you have to do it very, very deliberately over time.

So the good news about this, because about this time when you start thinking about the children that you care for and the children that you love, and you're thinking, "Oh, man!" Their brains have got so many things that need to be helped, need to be fixed, need to be worked on and resolved, but don't despair because your brain can change. All of our brains can change. We know that because, you know, we are working on ourselves in terms of new habits and healthy behaviors and things along those lines. It's hard, but it can happen.

Your brain is plastic. The actual technical term is called neuroplasticity. And it does continue to change, and we can purposely do that. So as a parent, as a foster parent, understanding that about our children's brains can lead us to do some things with our children that are good for their brains, that are good for brain development and help with that, you know, to sort of stimulate that growth, if you will.

One other example that we love to teach at the Attachment & Trauma Network, and, hopefully, you've seen this other places, too, but if you haven't, we definitely want you to see this. This is called the brain in hand model by Dr. Dan Siegel. And the reason that we think not only is it important for parents to know, but we also advise the parent to teach this to your children. It's a model of how our brains develop from the bottom up, from the inside out, and what can happen in the phenomenon that is called flipping your lid. So before I show you the model, I want to talk to you a little bit about flipping the lid. The diagram's here, and it's got a lot of the technical terms for the pieces of the brain that may or may not excite you and make you want to geek out, or, ha ha, they may confuse you.

But the flipping your lid part. I don't think there's anybody in the sound of my voice who hasn't flipped their lid. In fact, some of us have already flipped our lids today. I know I have. I mean, I opened an email, it said something I didn't like. It said something that upset me and frustrated me, and I could feel the emotions coming up inside of me, right? And I could feel--and so the next person who either walked in my office or called me on the phone was probably gonna get it emotionally. I was probably going to blow up at that person because my brain was about ready to flip. Now, we've all had that feeling before. Every human being has it. The nice thing about teaching this model to your children about the way that your brain works is that it normalizes the fact that we all flip our lids.

Now, children who come from hard places, children who have lots of--a background of trauma, especially attachment relational kind of trauma that we're talking about today, may flip their lids way more than the average child. But the importance is that when we look at this hand and brain model, we can show children that this is normal, it's normal for our brains to flip.

The question becomes, what do we do to keep it from flipping? Or what do we do after they flip? So here it is. Ginger and I are both going to do it. You can do it with your own hand, right? This is your brainstem here at the fat part of your hand. This is your cerebellum, the part that controls your breathing and the things that we don't ever think about: your breathing, your heart rate, all of those things. If you fold your thumb in, this is that limbic system, that emotional. So from the inside out, from the bottom up, these little infants, even though their physical brain looks complete, their actual functioning of their brain is about here, right? This part here that curls over the top, the cortex, the thinking part of your brain, hasn't really come online yet. That's why infants don't have language, they don't have deep, strategic thought, all of those things.

So when you curl this around and you tuck your nails up underneath here, then this is your cortex and this is your prefrontal cortex right where the nails are, right? And that's the part that's uniquely human for us and the part that we can strategically plan, that we can anticipate things, that we can multitask is all right there.

That part doesn't really come online until at least puberty and then kind of continues to mature, now the brain scientists say, clear up through age 30. So there's a lot of maturity that goes on there. So we're walking along with our little brain. Something happens, and our amygdala sends an alarm system, and, you know, this starts to flip out, right? And if we don't get control of that with this thinking brain, oops, we flip our lids and I goof up our slides. And that's a problem, right? But if we recognize when it's starting to go like this, then there are things we can do to calm ourselves down, and that's called self-regulation.

So the cool thing that we've seen both in schools and we've seen in person in families is that if we teach our children this, they can start using this as their tool to describe. "My brain's feeling like it's about to flip." And then we can help them, remind them of the tools that they've been taught, or teach them more tools if they're still able to think to calm down. Once this happens, once your lid actually flips, you cannot think, not logically think, and I know we've all had that experience. "I'm so angry...I'm so upset...I'm so out of sorts that I can't solve the problem with my head. I can't get inside and do the thinking pieces that I need to do. I have to do something. I have to take a break. I have to calm down. I have to call my friend. I have to take a walk. I have to..." whatever it is that we use for our calm down tools. So that's really what I wanted to share about the brain in hand model. Do you have anything else, Ginger, before we move on?

Ginger Healy: No. that's great. You can also teach kids that when it starts to flip, it's yellow; when it's down, it's green; when it's up, it's red. You know, so that you can just use that common language and give them the ability and control to express what they're feeling without having to use the parts that they can't have access to in those moments. So it gives kids a lot of power and control...

Julie Beem: Exactly.

Ginger Healy: ...in that sense. And, you know, we talk about parenting that whole brain of the child, and it's all going to come together. We really want to give you some really good, easy, sound tips to really do that, and part of that is what we call this paradigm shift of thinking differently about our kids than we may have viewed them before, looking at them through a different lens.

And one of the ways we can do that is how we view their behavior. If we really are able to take the emotions out and look at their behavior as communication--they're trying to communicate something to us--because most of the time, these kids don't have the language skills, they don't have the ability to verbally say, "Here's what's going on." "Here's why I'm mad." "Here's what I need."

We're way beyond that, especially when you really take into consideration developmental age versus chronological age. I think that's one of the best things you can do, is remember that although this child may be chronologically 10 years old, they're likely 3 or 4 or 5 years old developmentally, which means you're going to parent them and take care of them at that developmental age, not at that chronological age. So when you're looking at their behavior, it puts it into a different perspective. So I want you to think about, what's really going on underneath that behavior?

They're trying to communicate something. And it comes out in those reactions, especially in overreactions. But there is a neurological, neurobiological basis for those behaviors, for those reactions, especially the overreactions.

And now that you know that a child cannot access that prefrontal cortex until they're a certain age or a certain emotional age or are calm and regulated, that helps you to understand more that they are not in control of those reactions, you know? That's when we get to be a detective and we get to be really curious. "What is going on? What's changed? What happened? Did you sleep well last night? Have you eaten yet today?" At least with my kids, it comes down a lot to eating and sleeping and things that I didn't witness, but something happened, so giving them that benefit of the doubt and being a detective and figuring it out with them. Here's another really big shift I want you to think about, and it's called "can't" versus "won't."

Nine times out of 10, we have expectations for our child, we ask them to do something, and they do not do that. And we think, "Why won't they do that?," when in reality they cannot do what we have asked them to do. And it is because their lid is flipped. And sometimes we think that flipping of a lid means screaming, crying, hitting, throwing, spitting. Yes, it does mean that. But for a lot of our kids, it's flight or freeze, which means deer in the headlights, no response, right? It used to be kind of a button pusher for me when I would ask my son, "What's wrong?," and he would say, "I don't know." Well, once I learned that he truly did not know what was going on, what happened-- he didn't even know what I had asked him to do because he wasn't there. He had checked out, he had disassociated. He could not answer my questions, could not perform whatever task I had asked him to do.

You know, it felt manipulative sometimes, but I learned very quickly, this was not manipulation. This was that he couldn't. So I want you to try to keep that in mind: can't versus won't and give your child the benefit of the doubt that they cannot. Whatever it is, whatever follows that--they can't do their homework, they can't do whatever you're asking them to do. But like Julie mentioned, the best news about that all and the tips that we're going to give from here on out are because we can change their brains, we can rewire their brains, we can, you know, parent in a different way that helps them respond in a different way.

Julie Beem: Right. Exactly, which is part of the incredible wisdom in the quote about the importance. The single most important factor in our children's lives is that one stable committed adult. So while at ATN we talk a lot about therapy being important, about medication being a possibility sometimes, about all kinds of therapies and interventions having an impact, the biggest impact can really come from what we do day after day, but it's hard because that can't versus won't gets in the way--in the way because it feels so personal.

Sometimes a child does something one day, and it doesn't do it the next day. And we're thinking, "But wait. He was able to set the table without arguing with me for the whole week, and now all of a sudden, he's wanting to argue with me?" You know, "What made him do that?" And we have to explore that. And then sometimes it feels incredibly personal because the words and the actions are personal if you've been spit on, if you've had a child defiantly say, "You're not my real parent," "You're not the boss of me," "You can't tell me what to do," "I hate you," "You're the worst parent I've ever had,"--all of those really ugly, bruising things--it's really hard to hear that and not flip our lids ourselves.

So we have to practice what we preach in terms of understanding how to take care of ourselves so that our lids don't flip, and we can respond in a much more therapeutic way. Therapeutic does not mean we have degrees and practice therapy. It means that we're doing something that's healing, that's healing to the child. So our flipped lid, our response of anger, frustration, our fight, flight, or freeze to their behavior is not going to help them heal. It's not going to help their brain get the practice in regulating themselves.

So we have to figure out a different way. And the way that we do this at ATN is called the PATH Parenting model. It is a framework. It's not an actual model. I said “model.” Didn't mean to. And the way that it was developed is that we know that there are a lot of good trauma-informed, attachment-focused parenting models out there.

A couple off the top of the head that come to mind--circle of security, TBRI. There will be others referenced here and others at the end of the list.

But when we made this framework, we took all of those models, explored them deeply, and said, What do they have in common? What are the things that must be in place for us really to have a therapeutic framework to help heal trauma and build attachment?

So that's what you're about to see. We're going to go through it really briefly. We're obviously not going to train you in this framework, but we're going to talk to you about this through a set of parenting cards that we have made that talk about the essentials of this PATH parenting. And here are the 5 that deal with our parenting essentials. And there are 3 more that actually talk about essentials for ourselves in the self-care realm. But these are the 5 we're going to focus on today. And we use animals to do this mostly because we were making these for ourselves as much

as anybody else because a lot of the staff and volunteers at ATN are adoptive and foster parents. And we're like, What are good reminders and quick reminders to us of the tenets, the essential tenets, of this PATH parenting?

So the first one is the bear to help--everyone in the family feel safe. It is really important. And this is the only one that really comes in a true order. The others can, you know, just sort of flow in and out in terms of we need to remember them and use them as we can. But the most important thing that we can do is that we can keep everybody in the family safe. If people in the family are not safe, if you're in a situation right now that people in the family, whoever they are, children or parents, are not feeling safe, then you need to take some action. You have to address it. It's really important. You cannot create stability, you know, connectedness, any of the things we've been talking about, without safety first. And that means everyone must feel safe, including the parents. I know. A lot of us foster parents, a lot of us adoptive parents, we're huge givers. And we're really trying to help the children who come from really tough places. And sometimes those children bring with them really dangerous behaviors. And we have to be smart so that everybody in the family is safe, and we need to get help if that's not the situation. And everybody--I mean us, too. We don't need to be in harm's way. It's not good for any of us. I hope I'm not--I hope I haven't frozen here. I'm good? OK. Oh.

Ginger Healy: And I think the big thing with structure and nurture is the balance--high structure, high nurture. And that's really what kids need in order to thrive and blossom. That means that the structure is not too disciplined, not too authoritarian, but on the other end, the nurture is not too permissive. It really kind of requires a balance between the two.

And that comes through loving boundaries. Because of course boundaries have to be set. We talked about safety. Safety is nonnegotiable. That's number one--but boundaries set in a really loving way. And that comes into play when you're talking about transitions.

One of my sons in particular especially needs to know ahead of time what the plan is. Change is really hard for our kids. It can be a real big trigger. So we have to really be aware of that and be intentional about the plan. And we do that, also, by keeping their world small. And this can be really tricky. I understand, especially with other children in the home, children in the neighborhood. In our world today, we have a lot of kids doing multiple things--scouts, soccer, music, camp, on and on and on. And it keeps them really busy. But for our kids, sometimes we have to dial it way back down and just focus on the family unit, focus on keeping their world really small. They may not emotionally developmentally be able to handle all of those things. You know, having them go different places, that has to do with the transitions, you know. So keeping their world really small, really simple, and focusing on the attachment and the connection is really the best thing you can do within that.

And then, of course, that direct communication. A lot of our kids--you know, I think tone, volume, and cadence of our voice is key when we talk to our kids. It can really make a difference--eye contact. And, you know, our kids do not respond well to yelling. And so we have to be very careful with the authoritarian stance. It doesn't work. No one in the history of history has calmed down by being yelled at "Calm down!" That just doesn't work. So we have to be careful that the things we do with our kids don't make things worse because of their wiring, you know what I mean?

We don't want to strengthen the wiring that they have in their head that they're worthless and that they're being yelled at. So we have to really watch our language and our communication skills.

And I think that's what that next slide talks about, is just that balance in between that they need to feel safe and they need to feel seen. And so that's kind of how we do that. I think that's that next slide. I may have--there we go. Just that balance in between the two.

Julie Beem: Right. Yeah, and the hard part about that is that--I never get it right. I never get a perfect day when I've done my structure and nurture balance perfectly. A lot of it depends on how I was raised. I was raised in a pretty authoritarian family, and so it's very easy for me to go to the structure side. "You must do it, and you must do it my way." So then I have to figure out how to infuse more of the nurture. People who were in more of a permissive or free-flowing family, maybe to the far degrees, where there wasn't any structure, have to work hard to get the boundaries and the systems in place. So we have to know that for ourselves so that we know what to work on.

Ginger Healy: Right, right. I mean, this one is getting regulated. And regulation is the ability to manage your emotions. It's the skills we use to calm ourselves. And I hope you've heard us using that because it is just such a key tenet of what we believe in, is how we calm.

And maybe the next one kind of goes through all the different ways that we can kind of regulate, talking about co-regulation, and holding space. I--may be getting ahead of myself here, Julie.

Julie Beem: Right. Yup. Here I am. I don't know. I may be lagging a little bit here. But really, the importance here is that, you know, that we know that we have to actively teach this, right? Because, remember, they didn't get it when they were little. If you have biological children, those children's lids don't flip as often because they know how to calm themselves down.

You know, it's really kind of amazing that we have to teach this, but we have to teach it from a place of calm ourselves. So if we're upset, if we're screaming "Calm down," now is not a time to teach it. Now is a time for us to go get calm ourselves, do what we got to do, take a coffee break like this woman is doing here. Then there are steps called co-regulation, which is really letting these children, just like an infant would borrow that regulation from us when we bounce them around and we sing them lullabies, this is helping children regardless of their age borrow that regulation from us.

When Ginger was talking about that whole tone thing, one of the skills that I've picked up that's been so valuable with a dysregulated child is to attempt to whisper or get soft or get quiet because my children usually want to hear what I'm about to lay down when they've, you know, done something behaviorally they know they weren't supposed to do as their lids were flipping. So, you know, instead of that surprise volume that matches theirs, that whisper makes them lean in. That whisper makes them get quiet. And then just being present with them, you know, just reflecting back a calm, saying, "Man. That must feel really--you know, really hard," and giving them a chance. Their physiological, their brain system, giving it a chance to calm itself down.

And, you know, a lot of times, I used to do that by calming myself down, by sitting there quietly next to them, breathing deeply. And a lot of times, their bodies and their systems will eventually mirror mine. Why? Why does that happen that way? Sometimes they'll spin out of control for a while, maybe, hopefully, not hurting property, definitely not hurting themselves. We got to intervene if that's happening--or other people.

But why do they then start to calm down? Well, here's the brain part of why they calm down. We've got these things in our brain called mirror neurons. If you're walking down the street and somebody smiles at you--now, these days, they're wearing masks, so you don't see that--but if you did see them smile at you, you would have to fight back the urge to smile. If a baby is cooing and laughing and you're holding that baby, chances are pretty good that you are mirroring that coo laugh back because we're wired to do this. So because we know now that we're wired to do this, we can control that relationship, right? And so instead of the kid screaming and the dad screaming, the dad can smile, the dad can connect, the dad can represent calm, and that will--very often, not always because nothing ever works 100%--help the child to mirror back that calm. And then finally, when their thinking brain is online, even before they've flipped their lids, you know, we are actively teaching ways to calm down, ways to help ourselves, whatever that is. This picture's yoga. It could be anything.

Dr. Bruce Perry talks about--the 6 Rs in his programming about what it takes to create calm. And--the interesting thing, one in here, is

something that is repetitive, it's pleasurable, rewarding, and it's rhythmic. So lots of singing, dancing, drumming--drumming is fun if you've ever had an opportunity to do that, how fun is that--those types of things. In my kitchen a lot of times, we sing and dance. We sing and dance while we're preparing meals. We make up words to songs, you know, about our day, all kinds of that because not only is it playful, but it's also rhythmic and it's also rewarding to dance around the kitchen, right? And so it's just that whole thing. That's one of the things we do. Other families do all kinds of other things, but the idea is that it's repetitive, it's rewarding, it's rhythmic. Obviously, it's safe and relevant and respectful as well. OK.

Ginger Healy: Oh, and here's our otters. We love this picture. This is a mom and baby otter holding hands. And if you know anything about otters, you'll see them doing this often. It's called rafting. And it is a way for them to not lose each other when they are floating in the water or sleeping. And that just helps us to remember that connection--I get emotional about this--how important connection is and that we need to stay and do that. It is hard. It is especially hard when our children are pushing us away, right?

I can see all of you nodding your heads, like, "Yeah, that's the goal. Yeah, we want to do that, but how do we do that?" It is hard, especially when we have the older kids that are pushing us away. But there are a lot of things that we can do.

And "Connection Before Correction" by Karen Purvis, that is our TBRI model. We go with a lot of different models and frameworks in order to bring this together. And the other one here--

the Playful, Attuned, Curious, Empathetic, that's Dr. Hughes' PACE model. And those are ideas to help you remember how to stay connected. And being playful is one of them. Keeping it light, keeping it happy. We get really involved in these big, huge emotions that our kids have, and if we can pull out all the negative and just come back in with a more playful attitude, letting some things go, which I know is really hard. But letting things go and, you know, picking the lighter battles, being attuned to what they really need, being present, putting the distractions away. You know, just holding that space for them.

And then we also talked about being the detective and being curious. What is underneath that behavior? And then, of course, that empathy. Guys, we know how hard this is and what our kids have gone through. We can't even imagine what all these kids have gone through. So knowing that what they have gone through has brought them to where they are today and that we can change that will really kind of help us stay connected to our kids. And then our father penguin. You know, all that we have been talking about today is that being intentional. We have to have a plan. We cannot fly by the seat of our pants. That is the difference between parenting the children through foster care or adoption. Children with traumatic backgrounds require intentional parenting. We've got to be there, be present, parent with a purpose. We have to have our spouses or our partners that we are co-parenting with onboard with us. And, you know, we've talked a lot about staying regulated in order to mirror that and reflect that back, so...

Julie Beem: Mm-hmm. Right. And one of the reasons we picked this emperor penguin, one is because he's

a dad, and we wanted to make sure that dads got thrown into the mix here. We had the mama bear early. But the male emperor penguin actually holds the egg on his feet and keeps it warm--I believe it's 60 days before they hatch.

Ginger Healy: That's a long time.

Julie Beem: So that's a pretty good intention, right, standing there in the frigid Antarctic holding an egg on your feet, keeping it warm. And that's why you get these cute little pictures of the newly hatched babies underneath the male emperor penguin. And, actually, some of the literature we read said the moms were off having a spa day. Ha ha! They go to the ocean and swim while they're waiting for the eggs to hatch, which leads us to the last thing--the last point we want to make about this type of PATH parenting that we wrote. And that is that in order to continue to pour in--and it says "adoptive children," but it's true for foster children or any children who've had a background of trauma--parents really need to pour into these children so much that we need to be able to make sure that our own cups are full. That starts first by adjusting our expectations, by realizing that our parenting, our foster parenting, our adoptive parenting is not a typical parenting.

And we may have come in, especially if we're adoptive families. Foster families are pretty savvy. We, you know, especially after the first couple of placements, really start to get an idea of what we're up against, and then we go to trainings and we get good support. But regardless, this isn't your typical soccer mom situation. A lot of times, it feels like we're

rushing into a fire, because in a way, we are rushing into a fire. And our role is all of these things. We have a job description that isn't a typical parenting job description. We have to work on that therapeutic, healing aspect that we've talked so much about today. The responder, the trauma worker, and then we also have to advocate on behalf of these children in a lot of arenas. It may be explaining to a doctor how our child is different because of their early childhood trauma. It could be advocating directly with the school system or any other number of situations.

And in order to do all of those things, we have to take care of ourselves. We have to ask for, through the system, and insist upon getting, through systems and through other organizations of support, training, a break from the front lines. If respite is offered to you, take it. If respite isn't offered to you, ask for it. Insist upon it. Figure out a way to get it. You've got to have a break. Parents who are parenting typical non-traumatized children go out sometimes. Maybe not in this current environment as much as usual, but you do need a break away, a break to think. You need a chance to grieve anything that you are feeling, a chance to address. You might need to get yourself your own counselor or therapist. A lot of us have, and it's been an incredible benefit, and you need support groups. And if you don't have one, we have one for you at ATN. No doubt about that. So again, we want to drive home the importance of exactly this: Relationships are the agents of change, and the most powerful therapy is human love. So it's good to get your kids in therapy. It's good to get, you know, their counselors, their attachment-focused trauma, informed counseling and therapy onboard.

But the most important thing is what's happening right there in your home. We'll stop here and then tell Elizabeth that we're ready to take any questions and our answers. So that you can have this lined up, these are a whole lot of good resources. There's probably twice this many--[audio cuts out] The "Center for the Developing Child" is here and lots of great books by people that we highly recommend. Thank you, all. What questions can we answer?

Elizabeth Kramer: Thank you so much, Julie and Ginger. That was a lot of really great information. And I really appreciated you including the topic of self-care, which I think is so important. And I absolutely loved the picture that you had of the soccer mom and the first responder. I definitely associate more with one than the other. I won't tell you which one. We do have quite a few questions that have come in throughout the discussion, and also I would encourage our audience, if you have questions, please go ahead and put those in the chat box for us. We're in the Q&A section. And we'll go through them.

First one, just housekeeping, after this is over, are you all able and willing to share your slides? Can we go ahead and send those out to our participants?

Julie Beem: Yeah. I don't think there's anything in these slides we—

Elizabeth Kramer: OK.

Julie Beem: we're not looking to share. Definitely we'll get you a slide deck that you can share out.

Elizabeth Kramer: Wonderful.

If you could do that, I will see to it that it gets to the participants. And several of you also have asked again, the recorded webinar will be made available on the National Foster Parent Association website in their training section. So, obviously, if you're here and you're hearing us, you know, if you either want to watch it again or if you want to send others to watch it, that's where you'll be able to find it.

So questions. "Have you ever seen or do you ever see that an infant maybe once felt attachment or experienced attachment, but an event or change of home environment created an attachment problem?"

Julie Beem: Yes. Depending on what that is, yeah! Yeah.

Elizabeth Kramer: OK. So it's not necessarily something that happens.

Julie Beem: I mean, as Ginger said, we don't get to pick our trauma. So it could have felt traumatizing to the child, right, you know?

Ginger Healy: Things happen.

Julie Beem: They do.

Ginger Healy: Things happen through the lifespan. And the best thing--we didn't get into it--but there is something called earned secure attachment, which means that we can have attachment struggles throughout our life, but we can continue to earn that secure attachment style and work on it. You know, it can be a lifelong process. And we can build resilience at the same time to help that attachment strengthen.

Elizabeth Kramer: Excellent. So, sorry. I'm trying to work two computers at the same time, so opening up the questions on one and watching you all on the other. "How do we create attachment with older children?" That could be its own webinar.

Ginger Healy: That's exactly right. There is--absolutely you can! You can! You can! Our brains are plastic, and attachment continues to grow and change, so there's a lot you can do with older kids. You've got to be creative, and you can regress older kids, you know, when they're willing a little bit, because as we mentioned, they may be a teenager chronologically, but likely they are not a teenager developmentally. So it's OK to parent them at a younger age and do connecting things with them that you would do with a younger child. Find what they enjoy, what they like, and just pour into them all the connection and presence and regulation you can. And that will help build connection.

But we can talk later if you want to email about specific ways and ideas and tips and tricks on how to do that.

Elizabeth Kramer: Fantastic. I love what you said, too, about that sometimes, children are developmentally younger than their chronological age. And it reminded me, going back to your soccer mom graphic. I think that's where you get a lot of well-intentioned but false advice from other people, who will say, "Oh, you're babying that child," but they don't know that, actually, what you're doing is you're responding to the emotional age of your child and not the chronological age of your child. So I think sometimes the best advice we can give to people is to ignore the well-meaning advice of

friends and neighbors who don't necessarily know all of what your child has experienced.

Ginger Healy: Have to develop a little bit of a thicker skin. It is different. It is not less. It's just different. And we have to do what is best and right. And others may not understand that. We can educate them along the way, but we've got to have that confidence that we know what we're doing and we're moving forward. And we make a lot of mistakes along the way, and mistakes are great. They teach our kids--to make mistakes and that you can repair your mistakes--you can fix your mistakes. I make a trillion mistakes, and so I just have to go, "Oh, learning experience. Here we go." Ha ha!

Elizabeth Kramer: So this next question goes back a little bit closer to the beginning of the presentation. I think, Julie, you had given the example of a child who, or maybe--I can't remember, actually. Maybe it was you, Ginger. A child, you know, every day this week did just fine setting the table, and then today I ask him to set the table, and he melts down, and he's really just not capable of it. But, you know, you think, "Well, he's just, you know, maybe manipulating me." And so the question is, How do you know which it is? Because sometimes kids will try to just get you to do things that they don't want to do, or they want you to do it for them.

Julie Beem: Can you all hear me?

Ginger Healy: Yes.

Elizabeth Kramer: Yes. Oh. As soon as I said yes, Julie, now we can't. So, Ginger, I don't know if you want to jump in. When Julie's audio starts up again, we can have her answer as well.

Ginger Healy: Absolutely. Sometimes I think it matters. Sometimes I think it doesn't because at the end of the day, we still have to handle the situation whether it's manipulation or not. There is something going on behind that manipulation that they needed to do that, so, you know, sometimes that pushes our buttons and it makes it hard to respond. So, you know, we have to watch for that, but most of the time, it doesn't matter if it's manipulation because there was a reason behind that behavior. And once we can figure out what the reason is, we can address why they needed to do that so that they don't need to do that in the future. Do you want to respond, Julie?

Elizabeth Kramer: Yup, I think you're back.

Julie Beem: I think I'm back, too. No, I was just gonna probably say exactly what you said, which is that it doesn't really matter--I mean, if they're manipulating you, it's because they need something, right?

Ginger Healy: Yes.

Julie Beem: Something. So the manipulation is the way you feel on the inside as opposed to what they're actually doing. So if you can play detective, be curious, get underneath what's really going on there. And, you know, it could be something as simple as something physically is bothering them in the situation. I mean, we did a lot of detective work with my daughter and some sensory things as to why she acted out in reading class on some days and not on other days. And the detective answer ended up being it was the days that she rode the bus because of all the sensory insults of riding the bus and walking through when the bell rang and all of

the things, but it took us weeks to get to, why only on these days versus these other days was she struggling so? So it could be something that complex, or it could just be they had a bad day and they don't know how to talk about it, you know?

Elizabeth Kramer: Excellent. Excellent, great. Also going back a little closer to the beginning, we have some comments about trauma and brain development. And more a comment than a question. Just noting that it begins really in utero and that if there's substance abuse by a birth parent or substance use by a birth parent, that can certainly impact brain development and cause trauma in utero.

Julie Beem: Definitely, definitely.

Elizabeth Kramer: And the same person noted--and I'm actually going to read this verbatim so that I don't accidentally change the comment. "While it's fresh on my mind, last night my son and I had a first in-person visit with a behavioral pediatrician to address his neuropsychologically-assessed ADHD, inattentive subtype. And when we were discussing our forever family and I mentioned his trauma because of adoption, she"-- I assume the pediatrician--"asked, 'But he's been in your home since he was 48 hours old. How could his adoption be traumatic for him?' And she was serious, and I was aghast. So how do we get this information out to the medical community, especially those who are specializing in healthcare for children?"

Julie Beem: I don't know.

Elizabeth Kramer: That's a fair answer. It is.

Julie Beem: Except, I'm there with you, sister. Because I've been in those neuropsych developmental pediatrician meetings before and had very similar, you know, responses. What I do know is that the American Pediatrics Academy does have some documentation out there on trauma, not so much on attachment, because when they look at traumatized children, they're looking at a much bigger group of children than the ones that actually find themselves in our care. Our children are really the tip of that iceberg. But there is a growing understanding. Dr. Nadine Burke in California, who is a pediatrician herself and is now the first surgeon general of the state of California, is highly trauma-informed. You know, there's a growing movement among some pediatricians to get this information out there.

But, yes, it's, you know, the brain science is there. And even without drug and alcohol situations in utero with your child, stress hormones, the corrosiveness to developing brains of cortisol, in particular, of the stress hormones of the mom, can cause problems, can definitely cause problems. And the other thing that one would think someone who's studied pediatrics would know is that when a child is separated from the person in which they had resided for 9 months, they're going to know that. I mean, they're not going to be able to state that as a 5 year old, but at that point, they're going to know that they've lost that connection, that person. And, you know, how else to manifest that as an infant than in behaviors?

So, you know, I think you're right on track in pointing out that the trauma and that what they might be seeing as ADHD might actually be a hypervigilant response instead of a hyperactive response in that they're scanning their environment for safety. So all of those things need to be looked at.

Sadly, the professionals that you're using might not be willing to learn that from a mom or even from us, although we'd be happy to help if there was anything you felt we could do to help in that.

Ginger Healy: I think you can refer her to Dr. Burke Harris' TED talk. It's short and sweet and to the point. And if they have not read the ACEs study and learned about ACEs, you need to point them toward the ACEs study. We didn't have time to discuss that today, but that changes everything.

Julie Beem: Right.

Elizabeth Kramer: Excellent. Somewhat related comment. "It's extremely validating and affirming, Ginger, to hear about your son and his checking out. My son does the same, both cognitively and behaviorally. And I've always assumed that it's something I've been doing to him rather than something that's happening to him without my involvement."

Ginger Healy: Yeah, I'm sending big hugs to all of you. This is hard. It is hard, and I make mistakes a lot. And I used to take a lot of things personally. We keep going, and you are not alone. You are not alone. So...

Elizabeth Kramer: Excellent. Ginger, are you able to talk a little more about your comment about frustrations

when a child answers "I don't know"? Like, what are some healthy responses that have worked for you?

Ginger Healy: Yeah. You can help them--OK. Before a child can really answer your questions, they have to be calm. They have to. They can't access the memory. They can't access language. They can't access the part of their brain that will help them discuss and answer questions. So start with safety, start with regulation. Once they are calm--and you'll know that by their ability to kind of volley back and forth in a very gentle way--then when they do answer "I don't know," really, they don't. They don't know. So you can help them by saying, "I'm wondering. I'm wondering if you got enough sleep last night. I'm wondering if you're feeling scared. I'm wondering if something happened that..." I don't know. You can kind of without giving them the answer, because you may not know the answer either, kind of play that "I wonder" game with them. And then they go, "Oh! Oh! Oh, maybe. I don't know."

But just sometimes, we have to let it go, and maybe later, they can come back and go, "You know what? I've been thinking about it, and you might have been right, Mom." "Or maybe I..." whatever. You know, whatever the answer is.

Elizabeth Kramer: Got it. Perfect. Um...so interesting question, and I think really drives home the point that our children are our children, even when they're not legally children anymore. So the question is, "I adopted my daughter at the age of 23. I did not get her into foster care until she was 17. She's now 25. I took her out of an institution with

barbed wire over the top, where she was placed due to suicidal tendencies. It's still a struggle with attachment. What can I do for her at this age to increase attachment?"

Julie Beem: You can just keep trying. Really. That's it. With our young adult kids, it's really hard because developmentally, it's time to separate. So, you know, developmentally, she doesn't need you in the way, or need that attachment person in the same ways. So your relationship is probably always going to be a little bit different than what it could have been otherwise. And that's something, you know, I mean, I'm sorry about that. That's something that's going to have to be grieved on both of your sides.

But there's always hope. I mean, from a brain science standpoint, they've now extended the brain development till 30. You know, the active brain development until 30. And I can attest having kids in their 20s and 30s that, yeah, there's something that happens in your late 20s and early 30s that is different. And so, you know, if you were struggling before that, there's another opportunity for your brain to take things in and become more reflective.

And if she seems to push away at 25, it doesn't mean that she's always going to push away. You know, I think that's the takeaway. So, you know, leaving your emotional door open, continuing to try to connect, doing things that--for her. Also, you know, when she's open to talking about it, explain to her the science of what happened to her. There are support groups out through ACEs Connection and other places for adults who have significant backgrounds of trauma, significant ACE scores. And she might be able to use some of that, you

know, and then you're standing there waiting to help her with an attachment and a connection. You know, that's a good place for her to be when she's ready and if she's ready.

Elizabeth Kramer: Mm-hmm. You've mentioned ACEs several times. And for those of you who may not be familiar with it, that's the Adverse Childhood Experiences Study. And I went ahead and wrote that out in the comment box if any of you are interested in learning more about that. We also had a question just asking about specific respite care resources in Massachusetts. I put in the Q&A box a couple of related organizations lists from the Child Welfare Information Gateway site. It can enable you to search by state, but I did want to put that out to our presenters as well. Do you have any—

Julie Beem: Awesome. I do know in Massachusetts--I mean, here's your lucky day because I don't know all the specifics. But in Massachusetts—

Elizabeth Kramer: It's a quiz. We're going to go through all of them and ask you...

Julie Beem: An organization called Adoption Journeys, for adoptive parents--and it doesn't matter whether you adopted through Child Welfare, privately, or internationally--they will work with you. And I know that they have chapters, you know, around the state, doing post-adoptive work. Adoption Journeys, if that's helpful.

Elizabeth Kramer: OK. Perfect. So next up, we have a lot of questions. You all have definitely sparked a lot of questions and comments, which is wonderful to see. So you all talked about safety being nonnegotiable and safety being first.

So what do you do when a child who is acting out, and it's manifesting physically? They're kicking, they're biting, they're doing something that, you know, really places themselves or the people around them at risk for physical harm. And in this specific case, the child is 7. He's been doing it since he was 3. I imagine there's different techniques based on sort of the age and the size of the child. But what are some of the things that you recommend in those situations?

Julie Beem: The first thing I recommend is getting ahead of that, if you can figure out when it's about to happen. You know, the brain is here instead of here. Then whatever you can do to calm, you know, to help. I mean, the parents who deal with this kind of behavior often have to become the most creative. It could be taking a physical break. It could be if he isn't averse to touch, it could be something as simple as, you know, hugging, as swinging--you know, we use a porch swing a lot--as massaging his shoulders. I mean, if he is averse to touch, then you've got a different ballgame going on there, because a lot of times our kids have got sensory things, too.

We used this little magical stuff called magnesium cream that you can buy. It's actually Epsom salt dissolved into a cream. And I cannot tell you, except that magnesium is a common thing. I cannot tell you why it works so effectively with my daughter, but it did. And so if I could catch her before she was completely escalated, because, then, of course, touching her would just ramp things up-- but I would say, you know, "Can I give you a little arm rub or back rub," or whatever, and I would use that cream and massage it in. And it would

help. You know, if you're in the moment, you know, the help is, get them to the safest place possible, stay as nearby as you can safely stay. If you have to put a door or a half-wall or some kind of barrier between you, if what the child is doing damages property versus damaging humans, that's kind of where I always drew the line. It's sad when a child's dysregulation breaks things in my house, but it's not the end of the world. It's the end of the world when a child gets hurt or I get hurt or other children or pets get hurt. So it's like, whatever your safety plan is there. Ultimately, that's easier if you have other people in the home that can help enact that safety plan.

And if it's happening a whole lot, then you have to start looking about why it's happening, what can we do? You know, can we get other people involved? Can we get medication involved? You know, do we need the doctor to help us figure out if we need other hospital interventions or whatever depending on how big that problem gets. But the initial is, What can I do to know when it's about to happen?

My daughter made a very distinct noise, a little grunt, that meant she was--struggling. And that grunt--[Inhales sharply] became my trigger for a while, but once I realized that if I could do something, if I could act at that grunt, then I could help her figure out how to regulate, if that makes sense.

Elizabeth Kramer: I think that's such an interesting observation that you made, too, about your own sort of visceral response to her trigger.

Julie Beem: Yeah. And if she makes that--she's 23 years old and she still lives in our home, and she

does not flip her lid in a dangerous way, but every once in a while, she gets frustrated, and she still makes that little noise, and my central nervous system responds every time. Then I have to go, "Uhh. OK. Hang on." You know? "Calm down. Everything's good." But I usually go check on her when I hear that noise and say, "What's going on?" Because I recognize that she's feeling frustrated.

Elizabeth Kramer: Mm-hmm.

Ginger Healy: That cortisol can really build up in kids all day long. So if they can get rid of it through the day-- jumping on the tramp, running outside, playing with animals--that usually will help get ahead of it. The Epsom salt baths made a world of difference for my kids, too, like the cream. So getting ahead of it is great.

Elizabeth Kramer: Wow. I've never heard that before.

Ginger Healy: Yeah.

Elizabeth Kramer: Wow. That's fascinating. So we have a comment. But I'm gonna actually turn it into a question as well because I feel a need to respond to it. The comment is "I never really felt loved much by my mother, and I was once thrown out of the house at the age of 18, which created a lot of trauma."

Well, I think my first response is that I'm just so tremendously sorry that that was this person's experience.

"And my question for you all, then, is, as an adult, when you can reflect back on your past and realize that you've experienced trauma that is impacting you in various ways, what are

some of the things that we, as adults, can do to address our own past experiences of trauma?"

Ginger Healy: Well, I think there's lots that we can do. We interviewed--we had a summit a couple years ago where we interviewed some adult trauma survivors. And they all healed themselves in different ways. It was really beautiful, so it's a personal thing. But a lot did journaling, and a lot did therapy, and a lot did support groups, and, you know, on and on and on.

But there is so much hope in that, and just, you know, recognizing that you're not alone. And we're talking about trauma a lot more these days. ACEs is becoming, you know, a word that we use often. So you're not alone. And so there is a lot out there. I would get on ACEs Connection and join some support there and then find what feels good to you, whether it be journaling and talking about it or yoga or all those things that you can--if you haven't read "The Body Keeps the Score," please read that. It is such a healing tool for adult trauma survivors.

Julie Beem: And directly into therapy as well. You know, if you're able to get to a therapist who's using, you know, any number of trauma-informed therapies, like EMDR, like even ABT or other narrative work, like with the journaling and that type of thing, but, I mean, all of those things are great tools, but be proactive to do that, especially if you are in a situation where you're parenting now or you're thinking about parenting in the future. You want to understand--you know, you want to help yourself get to what Ginger talked about being, earned secure attachment so that

you're ready to help the children that come into your lives get attachment--get healthy attachment as well. And the way to do that--is to address your own stuff.

And even those of us who've had relatively healthy early lives still have a lot of that stuff, you know? And so it's good to do.

Elizabeth Kramer: Sure. And I think sometimes our own experiences of trauma in the past are maybe what have brought us to becoming involved in the child welfare system or to become adoptive parents of foster parents in some ways is to try to give back. And so I think it is so important to make sure that we have sort of identified and addressed our issues so that we have a full cup from which to pour into these children.

This is a pretty specific question, so it may be something that the asker can follow up with you via email, but I will put it out there maybe just for a quick response. "When should I consider medication for a 9-year-old adopted daughter from trauma, who is developmentally 3 to 6 years old and has rage issues--tries to break windows and doors--and is diagnosed with 22q deletion syndrome, which has been correlated to anger and lack of self-control?"

Julie Beem: Um, I think that's such a personal thing, you know, in terms of when you decide to use medication, although she sure has a lot of--I mean, there's a lot of indicators as to why you should do that at this point. Um...how old again?

Elizabeth Kramer: Chronologically, 9, I believe. Let me open up the question again.

Julie Beem: 9, right, OK. Because probably—

Elizabeth Kramer: Yeah, 9 years old, and developmentally 3 to 6.

Julie Beem: Yeah. You don't want to start too young. There are some other things you could try if you decided meds were not what you wanted to take on at this point in time because the challenge with medications is that there are still not really good ways to figure out which meds are going to work. So the psychiatrists and the neurologists who prescribe for us, even if they're incredibly insightful, often, you know, it's a guessing game. They might know what family of medications to try, but they don't know exactly, this one is going to work. So you have to, like, ramp up and then see what happens and ramp up and--So it's like these experiments. There are some things. There's a test called the GeneSight test that you can take that helps to try to--uses your DNA to try to factor in what meds might be more effective for you personally. So I would highly recommend doing that with kids. It's GeneSight as like... [Spells out GeneSight]

Sometimes your insurance covers it, sometimes it doesn't. But it helps, if you're getting ready to go on those medications, it gives all the families of psychotropic meds, and it tells you which one of those in the families is probably best for your DNA. So that takes a little guesswork out of it. But you can do other things.

You can look at things like neurofeedback. You can look at things like--what am I looking for? Um... supplement kind of things, like the magnesium-- that are generally not as--

Ginger Healy: Holistic?

Julie Beem: ...heavy hitter. Yeah, holistic. There we go--that are generally not as heavy-hitter things that you can do. And, again, it depends on how you're feeling about it. If the child is really small--and when my daughter was really small, she went on medications at about age 7. But prior to that, we tried a lot of things. And some things made things better. That's how we found the magnesium cream. And some things didn't make them good enough. But then we didn't have the GeneSight test, and we went through incredible trials over the next 7 or 8 years on and off, a couple of times actually requiring that she be hospitalized because the coming on and off of meds put her so out of sorts. So you're looking at a variety of different things there. But with a genetic issue on top of that, the chances are pretty high that--I mean, the goal is, What can I do to lessen my child's overall load here and make it easier for her to stay calm, make it easier for her to be able to connect, simplify things for her?

And if meds have to be a part of that, then, you know, we just have to do it as smart as we can. And if you want to talk to me more about that, I'd be happy to do that. Just email. Drop me an email, and we can talk some more.

Elizabeth Kramer: So we can handle this a couple different ways. We're right at time, but we do have several more questions. Do you have time to take a few more questions and run a little bit long, or if not, I can email the questions and maybe you all can respond to them and we can distribute that to the group? Which would you prefer?

Julie Beem I'd prefer to keep going if the technology--

Ginger Healy: Yeah, that's fine with me, sure.

Elizabeth Kramer: No, we're fine. I want to be respectful of your schedules. Related to that last question, what are some tips or some guidance or maybe some questions you can ask when you're working with a psychologist, a psychiatrist to make sure they're really attachment- and trauma-informed? Because I think not all of them are. More are starting to be. But how do you go about sort of--I don't know--interviewing them?

Ginger Healy: That's a great question. Um...

Elizabeth Kramer: Oh, Ginger, somehow, I don't think we can hear you. Can you try again?

Ginger Healy: Can you hear me?

Elizabeth Kramer: Very faintly.

Ginger Healy: I don't know why.

Elizabeth Kramer: Oh, goodness. What a cliffhanger on this question.

Ginger Healy: Can you hear me now?

Elizabeth Kramer: There you are. Much better now. Great.

Ginger Healy: What was the question? How to weed through. You know, that's tricky because some of us live in rural areas; some of us have insurance that, you know, doesn't cover. And so we do--and maybe Julie was going to talk about this more. In fact, I'm going to hand it over. I don't know if you were going to talk about the directory or things that would help find more. But a lot of times, talking with other parents about which

doctors have worked for them and what they know and kind of networking that way. What else, Julie?

Julie Beem: Yes.

Ginger Healy: Oh. Ha ha! Darn it.

Elizabeth Kramer: The Fates are conspiring that we're not going to be able to answer this question quickly. I think that's a great point, though, that you made, is that the question itself assumes that you have choices. And you're right. In some rural areas or depending on your insurance, maybe...

Ginger Healy: It's tricky.

Elizabeth Kramer: Yeah, maybe getting an appointment with anybody at all is—

Ginger Healy: Mm-hmm. Sometimes there are several months waits. So...

Elizabeth Kramer: Yes. And that's incredibly frustrating. Yeah.

Ginger Healy: I think--oh, there you go, Julie. Try again.

Julie Beem: Here I am. Yeah. I guess I wasn't destined to answer this question. Ha ha. The thing that I guess I would say about finding the right folks, one of the blessings, if you will, of being quarantined right now is that so many of the professionals are doing telehealth. And so while you might have trouble schedule-wise getting in to see somebody, you're not as confined to, you know, somebody within 25 miles of your house. I don't know how much Ginger told you about the directory that we have been so fortunate to have funded by

the Hilton Foundation. We're in the process of finalizing it and hope to have it launched by September. But it will be a directory of professionals...

Elizabeth Kramer: Wonderful.

Julie Beem: …everywhere from clinicians to residential treatment centers to parenting coaches that opt in specifically because they are trauma-informed, because they know about the ACEs work, they understand trauma-informed modalities, they understand what happens in early childhood. And many of them also have attachment-focused practices as well. So we're excited about that because it will become, you know, a several-thousand-person directory that you'll be able to search. And, hopefully, it will continue to grow and we'll continue to find resources because we now have a staff person actively looking for those.

It is a problem. You know, individually if that's something you're looking for and really struggling with in your location, shoot us an email, and we'll have our resource person tell you what resources we know of to help short-circuit that a little bit until the directory's up and running completely.

Elizabeth Kramer: Excellent. Excellent. And one of the participants also mentioned the Center for Adoption Support and Education, or C.A.S.E. And they have a database as well...

Julie Beem: C.A.S.E. That's a wonderful resource.

Elizabeth Kramer: …of adoption-competent therapists. So those are a couple of resources. So let's see. "If a child fixates on their way or the highway

for a situation and they cannot have their way, how do you stop that cycle and help them move on? He often uses threatening behavior to try to get his way."

Ginger Healy: That is tricky.

Julie Beem: Does it say in there how old he is?

Elizabeth Kramer: It does not say. So the person who originally answered the question--I think 7 now. I think this person had asked on some earlier questions and said that the son is 7.

Julie Beem: So think about his brain this way. When his lid is flipped because he wants his way--highway or-- I mean, in other words, you've told him no, and that's a huge trigger for a lot of our kids, that no. So he goes into kind of a vapor lock in his brain. You know, like, "I can't be moved. I can't change because..." you know, "Mom has told me no again. I need to get what I want." The chances are pretty high, probably--let me just make this assumption, too--that if you actually were able to give him what he wanted, that wouldn't necessarily immediately calm him down. He probably still had some vapor lock left over, right? It's because his brain is used to ramping up. His brain is expecting to hear the no. His brain--it's that whole negative, you know, firing together, wiring together kind of response. If that's what you're seeing, what I do for it--it sounds kind of wonky, but it works sometimes, and sometimes is what you're going for--is I would prescribe the behavior before it happened.

So if I'm about--if we're all about to do something and, you know, we're all in Wal-Mart and we know he's going to ask for

the candy or whatever the situation is, and you know you're going to have to say no, then I would brief him beforehand. "Hey, man, we're about to go into this situation. And I know you, and I know you're going to ask for this, and today you can't have that. So I just want you to be ready right now, and if you have to get upset, let's get upset right now here in the car."

Well, a lot of times, our kids that have that oppositional tendency, that thing that gets diagnosed as oppositional defiant disorder sometimes, their brain won't go into that vapor lock because now they're like, "OK, I don't know what to do." You know, now it's new, and we have to think about that.

And maybe they will, and you're in a safer place for them to have that meltdown than other places, but you're prepping that. You're prescribing it. "It's OK to get upset about this because I know it's hard to hear, but you're not going to get to do this." And then you just wait for the reaction. And because you've given them permission to get upset, a lot of times their brains won't go that way. Because-- they're so used to having to defend their anger and get all up in that threatening kind of position.

Like I said, it doesn't work 100% of the time, but you might experiment and try that. It sounds super counterintuitive, but it's also insightful to say, "Hey, I know this is hard for you now." And it's kind of like you're positioning. "I'm on your team." You know, "Me telling you no doesn't mean we're adversaries. Me telling you no means I'm on your team, and this is what we need to do because it's what's best for you and best for the family and best in

the situation. So I'm telling you upfront so that you know." Just see if that works.

Ginger Healy: Yeah. Our kids are just desperate for control because they have lost control in every single other aspect of their lives. So a lot of behavior stems from that "I need to control this situation." Negative or positive, it doesn't matter.

So if we can give control in safe ways and as often as possible and get ahead of it--because we do have to set those boundaries, and we do have to say no, but we can say "and," and we can, you know, say "yes." Here's where the yes comes in. "You're not able to have this, but you can..." We can do this.

Julie Beem: These things. Right.

Elizabeth Kramer: Excellent. Excellent. So the next question: "I adopted my daughter at the age of 10, and she's now 16. She's very resistant to counseling. She hasn't been in therapy since the age of 13, and she refuses to return. Do I let it go and trust that she'll come to it if and when she's ready? She has self-regulation and attachment challenges."

Julie Beem: That's hard.

Ginger Healy: [Laughing]

Elizabeth Kramer: Yeah, none of these questions are easy. I don't have a low ball.

Julie Beem: I'm sorry she's 16. That's right. I'm sorry she's 16 because that's hard even if you haven't come from a background of trauma. And there is a point, and that's somewhere around that

14, 15 years old is usually when you hit it, especially for girls where you can't make them, you know, get anything out of therapy.

So why waste your time and dollars trying to do that unless they're ready? You know, leave the door open on that. And, you know, that may not be the battle that you decide that you want to pick. You may want to try to--you know, there might be other ways that you can try to help enhance her attachment or help her with regulation. There might be other activities that are self-regulating that you can figure out how to get her involved in.

Ginger Healy: Honestly, and I'm a therapist, I will tell you that time with you as a positive, stable, committed caretaker, hours of that is more valuable, more productive, more progressive than an hour in an office with an awesome therapist. Ha ha! So, yeah, therapy is great. You should do therapy if you can and if she will, but don't let her not doing therapy make you think that all is lost. You can do even more.

Elizabeth Kramer: Excellent. Good, good. "How do we help get our children past hypervigilance and able to start learning academics in a school setting?" I guess assuming we ever get back to a school setting.

Ginger Healy: That's that safety.

Julie Beem: Yeah. And there'll be a school setting. It just may be in your home. Yeah. And some of it is that the adults, the educators, just like the parents, recognize that that's what it is. I mean, it's really important that the educators understand, you know, about trauma-informed education in systems. And, you know, we had

somebody talk about the pediatricians and, "The developmental pediatricians don't understand." Well, neither do a lot of the schools, although ATN is working on that in our schools program actively. But the teachers have to recognize that type of vigilance to work to help your child feel safe. And that's something--that's work that's hard for us to do as parents, because we're not there in the school helping our child and depending on how much the child has as far as self-regulation skills, but it's really astute that you noticed that they can't learn when they're hypervigilant.

Ginger Healy: They can't. We have to kind of let those academics go. They're not going to fall into place until we have all the other stuff.

I did a few webinars in the summer for teachers and parents with Ilene Pawlak, who's on our school team. They are on our website, and they're short. They're, like, 10 minutes each, and they're school-specific, parent-specific towards our situation. So if you want to try to access those, they're really helpful. So email us if you have trouble finding them, and we can link them.

Elizabeth Kramer: And sort of related to that in terms of accessing your resources, the PATH model cards. Are those available for downloading or purchasing? Also come to your website.

Julie Beem: Yes, they are. They're available to purchase. Come to the website.

Elizabeth Kramer: OK, I will post your website so folks have it. Just a couple more questions, and then I'm going to let you all go. Oh, this is a hard--they're all so hard. "How do you deal with an 11-year-old

child who threatens suicide when she doesn't get her way? Her therapist believes it's manipulative."

Julie Beem: Um...I don't know if I would use the word manipulative because that's one of the words I try to take out of my vocabulary around what our kids are doing. If they're manipulating a situation, it's because they need something. And we have to start thinking about it in terms of, what is it they need? I think what the therapist was trying to say, that it's the therapist's opinion that she's highly unlikely going to follow through on that action.

And that could very well be true. It's just that knowing that that threat--that's a threat--you know, that she's threatening to do that causes a response in everybody, you know, and gets a reaction from everybody.

So if I start thinking about it, that's how I would start thinking about it. OK, she's doing these things. You know, she's saying that she's going to kill herself. That's a huge signal that she's way upset and that her lid is flipped and that she needs some kind of a response. So can I head that off? Can I address--it directly? I mean, that's her--that would be how I would play detective. I don't know what else Ginger's got on that, but that's—

Ginger Healy: Yeah. There's something behind that for sure and what she's getting out of that. How can we recreate that in a different way, you know, whether it be the attention of whatever we can give attention? We can do that, you know?

Julie Beem: Right, right. Yeah. However you can explore that with her and get curious about that, why

killing yourself. Why do you feel so hopeless about these things? Or maybe she doesn't feel hopeless. Maybe there's a different emotion that she's feeling around that.

But just digging into that a little bit. If she senses that there's any, you know, fear or big emotion that you're having about that threat, that could just be enough for her brain to keep trying to do that. And so as odd as that sounds, you're going to have to get comfortable with trying to go underneath that and ask why.

Elizabeth Kramer: Yeah, I can imagine, even if you hear it with some frequency, it must be a terrifying thing to hear. I can only--myself, I'm sitting here having a visceral reaction to it, you know?

Julie Beem: Yeah, and at the same time, if you truly believe that she's going to act on that behavior, you—

Ginger Healy: Yeah. We're not saying don't take it seriously.

Julie Beem: ...but if it's happening frequently--and a lot of our kids do say that: "I'm going to kill somebody else," or, "I'm going to kill myself," or, you know, the big stuff like that, then, yeah. Then you have to try to figure out what's going on underneath that and what can we do to, you know--what does it make sense to do to ferret that out?

It's hard. None of these are easy.

Elizabeth Kramer: Yeah. Well, I have another tough one for you and then a couple more, and then we'll be done. But they don't get any easier, so don't get too comfortable. "Can you offer any information on compulsive masturbating? My 9-year-old daughter seems to use this to

self-soothe and has since we got her at age 5. I've heard it's OK. I've heard it's not OK." I imagine this is one of those places where you get a lot of well-meaning advice from people who, you know, maybe you should take their advice, maybe not. "I'm curious as to your expertise on how you would handle this." And this, again, is a 9 year old.

Julie Beem: 9 year old. OK. Um, my expertise is not--the only expertise is a mom, so we'll let Ginger do the clinical side of things. But the two things I'd be thinking about were, is she doing it in private so that it's not bothering anybody else? You know, so that isn't a problem. So then that isn't a problem. I mean, if she's not attempting to do it in some way to be--for everybody to see it. If she's able to do it in private, OK. Is it significant enough that it's causing physical injury, physical problems? Then that's another reason that I might intervene. And other than that, I probably would just let it happen. I mean, as a mom, yeah, I've probably got other fish to fry, and I would probably just let it happen and maybe be actively thinking about other comforting things...

Ginger Healy: Yeah, self-soothing, self-comforting. I mean, that's usually what masturbation is about, is comfort, and it can become addictive, you know, because it can feel so good. So you want to, you know, ramp up the connection and then, you know, regulation because it can calm down if that's what's going on. But the one thing we don't want is to shame the child. Above all else, avoid shame. And I say that about everything. We're not just talking masturbation. We are talking, Please, please, please never shame your child.

Julie Beem: Right.

Ginger Healy: They will carry that with them forever, and you won't have solved the problem. In fact, it'll probably have made it worse because they'll need comfort.

Elizabeth Kramer: Made it worse.

Ginger Healy: Yeah. And then the shame builds, and it's this horrible cycle. So, yeah, keep them safe, keep them private, you know, and all of that, but usually, there's something behind it, but with that repetitive behavior, you know, then usually if we can substitute it for something else, you know, once everything is kind of in a non-shaming way and ramp up that connection because that's the self-soothing, self-comforting need behind it.

Julie Beem: Right.

Elizabeth Kramer: Excellent. Thank you.

Julie Beem: Yeah, I guess the only other caveat I could think of is if you know your child has a history of sexual abuse, that might lead you into a kind of a session...

Ginger Healy: Very possibly.

Julie Beem: …with a therapist that--you know, about that. So...

Elizabeth Kramer: And, Ginger, great point about shame. I think that it's such a powerful--

Ginger Healy: That's another webinar, right?

Elizabeth Kramer:	That's a whole other webinar, yeah. I've got a list, you know?
Ginger Healy:	Yeah.
Elizabeth Kramer:	Yeah. I'm just going to set up a web channel for you guys. But I do. I think shame is just--it's so powerful. And I think so many of the young people that we see already have a lot of that. And, yeah, I think you're absolutely--it's a good point taken that we don't want to add to that. I'm going to go ahead and close with this question. So it starts with a thank you, which I also want to echo, but also a thank you to the asker because they start their question with "We foster teens exclusively," and thank you for that. And part of this reason this question jumped out at me is they said, "We've had so many issues with attachment that we're at the point that we're not sure we're going to continue to foster. So if you have any specific resources about attachment and trauma with teens, especially teens who have been in and out, returned home, then removed again, I would be so appreciative. If there's a future workshop about teens, that would be awesome." I would love to put that together, but in the short term, if you have any resources, foster parents are just--they're in such short supply, and they have the hardest job. So I hope that what we've offered today has helped make that job a little easier. And I would love to offer something in the future specific to teens to make it easier, but just as we close, do you have resources available? Is that another place that we can have people visit your website?

Ginger Healy: I have done some interviews with parents who have, you know, fostered teens and parented teens and dealt with teen issues. Oh, I just forgot what else I was going to say. But I know this is hard, and it feels a little hypocritical saying it, but it's not personal what these kids are going through. It feels personal--it is--but it's not. And that's where I know that I'm getting burnout and have secondary victimization and, you know, am getting PTSD, which sometimes is when I'm taking it really personal. And it's so much easier said than done, so I want you to know that. I'm not saying, "Don't take it personal." But just know that what these kids are going through and what has happened is not your fault, you know, is not what you--you're just trying to hold that space for them is enough. It's good enough parenting. Really, just don't try to be perfect, and everything that we've said today, it's so much. Just pick one thing. Just try one thing. Just keep going. Just hold that space and be present. You don't even have to say anything. You can just be there, and that is enough. Just be good enough for today, let everything else go. Be gentle with yourself, you know, because it's such a heavy load, and I feel that for you.

And so I understand. And if you need to take a break from foster parenting, you need to take a break. You know, you're not going to do any good if you have nothing left to give. So that's OK. I'm giving you permission for that, you know, so...

Elizabeth Kramer: If your cup is empty, take the time. You need to refill it.

Ginger Healy: It's empty. Yeah.

Julie Beem: Exactly. Yeah. Our groups at ATN, our support groups, can help you. We do have a lot of families who are at that teenage period, either adoptive or foster, that provide probably way more wisdom than we could come up within a webinar--ha ha--to each other all of the time. And a lot of it is about, you know, being able to provide that opportunity for them to connect with you but still not expect that side of the relationship. I mean, that's the hardest part, is we're wired for that two-way connection. So we're wired to get back something, to feel good about those kids. That's the way that, you know, to have a relationship with them, and it's a two-way street. And a lot of our kids can't give that way back to us as teenagers, and so we have to have other relationships in our lives—

Ginger Healy: Yeah.

Julie Beem: …spouses, others that can give us that two-way and fill us back up so that we can just--we can hold open the doorway for them to possibly reciprocate that relationship someday, but they may not ever quite get there. So, yeah, that's a hard job. That's about the hardest job there is.

Elizabeth Kramer: It is. Absolutely. Well, Julie and Ginger, I want to thank you both so much for agreeing to participate today and for sharing your personal and your professional experience. It's been really, I think, wonderful to have those different perspectives in the both of you. And thank you, also, to your families for sort of letting you share their lived experience as well. This has been wonderful. Thank you especially for staying on extra. I do a lot of webinars,

and this is probably the highest number of questions and comments that I've seen.

We have a lot of really engaged audiences, but this is clearly just such an important subject. And I feel like we could probably stay on for hours and we still wouldn't get through everything. But just thank you both so much for the work that you do and for sharing your wisdom.

To our audience, I've had several questions about certificates. I believe those will be sent from the National Foster Parent Association, so they will not come from Gateway, but they will come from the National Foster Parent Association so that you'll have documentation of your participation today. But, again, just thank you so much. Thank you to the audience for being so engaged and asking such fantastic questions.

Julie Beem: Yes, thank you. Great questions.

Elizabeth Kramer: Really, really good ones. Yeah. Wonderful...

Julie Beem: Thank you for doing in your homes what you're doing. It's so important.

Ginger Healy: Stupendous.

Elizabeth Kramer: Absolutely. Yes. Thank you. And keep your cups full.

Julie Beem: Mm-hmm.

Elizabeth Kramer: All right. You all take care...

Julie Beem:	We can help you. Reach out.
Elizabeth Kramer:	Yes, please. Please. Thank you so much. Bye-bye.