Understanding Trauma-Informed Care to Build Parent Resilience

Sangeeta Parikshak: Good afternoon, everybody. This is Sangeeta Parikshak. I'm the behavioral health lead for the Office of Head Start, and I'm very pleased to be here with you for our second full week of the Head Start Heals campaign. We have a wonderful presentation for you all today. The topic is Understanding Trauma-Informed Care to Build Parent Resilience. We have so many registrants. Today I believe we had 6,500 people register. We are very thrilled that you have such an interest in this topic.

And I do apologize as the e-blast went out so late last week, and yet we have so many folks on. For any colleagues of yours that aren't able to join us today, just wanted to let you know that this — that this is being recorded and we will — we will be able to offer it to you in a couple of weeks. I wanted to introduce our presenters for today. We have Dr. Marilyn Bruguier Zimmerman, who is here with us from the National Native Children's Trauma Center. She is the co-principal investigator and senior director of policy and programs at the National Native Children's Trauma Center.

She's the former tribal senior policy advisor at the Office of Juvenile Justice and Delinquency Prevention, and founding director of NNCTC. She has been a member of numerous national, state, and local committees and work groups, including the U.S. Presidential Commission to Eliminate Child Abuse and Neglect Fatalities, and the Advisory Committee of the Attorney General's National Task Force on American Indian-Alaska Native Children exposed to violence. She provides expertise in trauma-informed systems change and systems serving AIAN communities.

I had the pleasure of hearing her speak in our Region VIII opioid event where she was there with all of our Head Start staff — or our Head Start family from Region VIII, and so just really thrilled that she agreed to come and present with us to you all today. After her presentation, we're going to have Dr. Josh Sparrow. He is the executive director of the Brazelton Touchpoints Center in the division of Developmental Medicine at Boston Children's Hospital.

And you also know him from — as being part of our National Center on Parent, Family, and Community Engagement. He's the co-principal investigator for our National Center, and he's also a associate professor in psychiatry at Harvard Medical School. In 2010, he was appointed to the Health and Human Services Secretary's Head Start Research and Evaluation Committee, and he serves on the AIAN Head Start Collaborative Advisory Council as well. So, we're really thrilled that he can be with us today.

After Dr. Zimmerman's presentation, he is going to join us to help facilitate a discussion around your questions and, will provide some insight from his own expertise with working with Head Start families. So, really thrilled that he could be with us today. Just a couple of housekeeping things for you all. If you have any questions, we really encourage you to submit questions. We already see a bunch coming in already, but if you're wondering how to do that, please use the left sidebar to ask questions, submit comments, or download any handouts. Our slides today will be available to you there, at the bottom there, under "Event Resources."

So, please go ahead and feel free to download as we're talking. I also wanted to let you know that we will be sending you a certificate within two hours after the webinar concludes today. So, just to make sure you know how to use that chat box, if you could also let us know what your role in Head Start is. That will really help the presenters today to understand kind of your perspective, where you're coming from. And we can tailor a lot of — a lot of your — a lot of our answers to, depending on kind of where you sit in Head Start. So, with that, I would like to turn it over to Dr. Zimmerman.

Dr. Marilyn Bruguier Zimmerman: Good morning, everyone. I'm really humbled and pleased to be with you all, and in my part of the country it's this morning. So, welcome. I love this quote by Brené Brown. I use it often on my slides because so much of about when we talk about trauma or trauma-informed care or approaches, it really is about the story that we've lived.

And, I want to say right away, that our trauma histories are not a life sentence, that we have the capacity and the ability to heal. And that's a little bit about what we're going to be talking about today. So, it's very much about thinking about how to support parents in rewriting their own — a new story, a new ending to their story.

As always, when we think about — or want to talk about — the impacts of exposure to violence, or grief, and loss, we have to have — provide a note of caution. Because many of us, as we know, have our own trauma histories that we may be well on the way to healing from, or it still may be something that we're working on.

So, just know that if you are experiencing upsets feelings, and they don't subside, please reach out for help. Most of the time I have this slide up when I'm in an audience, a live audience, and I'm standing in front of them and I often tell the story about the crisis text line, which I love to promote. I'm also on faculty with the social work department at the School of Social Work at the University of Montana. And I have to tell you that the, this new generation of students, and young people and young youth, are very much around texting, and Snapchat, and Instagram.

And so, whenever I have to get ahold of the students and they don't answer their emails, and they won't answer their calls, or return calls, I text them and probably within 30 seconds, I have a response. So, this crisis text line is really a wonderful text line. It allows young people from all over the country to reach out for support, for any crisis — whether it's food insecurity, housing, suicide, issues with gender identity. They have the capacity to support those students. And of course, always promoting the National Suicide Prevention Hotline, and understanding that as part — as part of this conversation today, that we have to understand that as Head Start professionals, professional caregivers, or parents, that we have the responsibility to take good care of ourselves.

And so, it's very important that your — your well-being is really critical to the care of Head Start children. So, I want to talk about the National Native Children's Trauma Center and how it came to be funded, and a little bit about our history, because it'll put a context to this conversation. So, we're part of the National Child Traumatic Stress Network that was created in the early 2000s to really address the needs of children and youth who had been exposed to violence. That was the initial conversation, and it was after 9/11, when American society was thinking about and talking about the impact of missing or experiencing a terrorist attack on our own soil.

And it wasn't just the adult mental health that they started thinking about, it was very much about what are the impacts on children. And those that had been working in the field said, "Well, it's not just about terrorist attacks — attacks, it's all about all kinds of ways that children experience traumatic events."

Whether it's, you know, witnessing domestic violence, being the victim of sexual abuse in their household, bullying, gang violence, that sort of thing. And so, Congress created funding to create a network that they flowed through the Substance Abuse and Mental Health Service Administration. We started out as a Category 3 trauma center in that network, which is really a direct service with ...

So, it could be a child welfare agency. It could be a school district, it could be a mental health center — community mental health center, an emergency department, whatever that looked like. And we were funded, to basically ... The big idea around the network was that we were going to take evidence-based trauma treatment models and embed them in settings that served children so that the children who had experienced dramatic events and exposure to violence would have appropriate treatment rather than, you know, some of the therapies that were not necessarily created for, or useful in, treating PTSD-like symptoms in children or childhood traumatic stress.

So, we started out as a Category 3, and we are housed at the University of Montana in the College of Education. And what is interesting about that is that we have, back in 2003, and '04 and '05, we were hearing from school administrators, teaching staff, special ed staff, asking us or telling us actually that, you know, that the kids in their school districts were being diagnosed with ADD or ADHD, but the medications that they were being prescribed, or the strategies that the teachers were being taught to ...

Oh, I'm sorry. I need to speak louder. That we were being — that they were working with the students and they asked, "Could it be something else?" So, about that time, the original director of that Montana-based center looked across the country and found the Los Angeles Unified School District, Dr. Marlene Wong, and her team had created something known as Cognitive Behavioral Intervention for Trauma in schools, or CBIT for short, and it was very much about really looking at the childhood traumatic stress symptoms of students who were urban, Latino, predominantly Latino immigrants, and it was definitely this intervention. It was a small group intervention for, you know, eight to 10 students for six to 12 weeks, and it was provided in a school setting.

And it was also in the early 2000s that we were having conversations — conversations about how schools were the defacto mental health centers in this country, and still, many, many students, children, and youth are identified with — with mental health issues in a school setting. So, they — we took the CBIT model, and we took it to two reservation communities, and we asked the question, "Do American Indian children and youth suffer from PTSD-like symptoms or childhood traumatic stress?

And if they do, will an evidence-based treatment model that was developed in an urban Latino-immigrant community, work in a rural American-Indian community? And the answer to both of those questions was yes, the — that it does work. Well, what we found out was that for the

American Indian students in the two school districts on reserve – public school districts on reservations in Montana, that there were extremely high rates. In fact, in one middle school, there was 100 students, and 75 were screened or assessed as having full blown PTSD or childhood traumatic stress symptoms. So, we had an ethical responsibility to respond to that kind of need.

So, early on, we took the CBIT model and created a curriculum that is free, and called STAR — Students Trauma and Resilience. But what was most interesting, I think about that first study is, is that these kids were telling us, you know, "Watching mom and dad's fight is really hard, but grandma dying is harder." "You know, my uncle — 40-year-old uncle dying in a car wreck because he was under the influence is harder."

"My best friend dying by suicide is harder."

And at first some of us who are in — who had come from child welfare background thought it might be a red herring that these students may be trying to be protective of their families and didn't want to account for exposure to violence in their households. And so, they started to talk about their grief, but we did a second study and we did find that for American Indian kids, and now so many years later, we find it's not just American Indian kids but different populations, homeless youth.

It's, if you think about the losses that our children, our youth experienced as children in child welfare, grief and loss does account just as much for their PT — their childhood traumatic stress symptoms — as does exposure to violence. It was always also at this time that we had to have a conversation about how do we work in tribal communities. As university folks, researchers, and interventionists and trainer — training and technical assistance providers, we were very much a part of the conversation about honoring tribal sovereignty, and how to work respectfully and thoughtfully in tribal communities.

And so, we always acknowledged that the tribe owns the data of whatever intervention. We follow the lead of the tribal leadership on — on the expressed needs of the community, not necessarily what we find interesting to think and talk about. And we try to be relevant and helpful in tribal community settings. So, what we really found out early on was that it was really wonderful that the intervention did work, but like the rest of the network, and I think that anybody that's involved in implementation science found out that it's really difficult to embed an evidence-based treatment model in the context of a system that isn't trauma informed. And so, in a ...

Probably right around 2010 after we were funded as a Category 2 — which we provide treatment adaptation to evidence-based treatment models, and they also provide training and technical assistance to tribal communities and all kinds — every system that you can think of that touches the life of a child. What was I saying? What was I saying? So, yeah. So, we did — we — we found out that it was really difficult to embed it in the context. So, we started really looking at how do we create those census systems? What are — what ... How do we know that a system is trauma-informed?

What are the trauma-informed approaches that can be most useful in a school setting, in a child welfare setting, in a juvenile justice setting? So, that's who we are today. So, why do we need to

talk about trauma, really? Is it — is it just something that we've been, you know, since the ASIS steady has happened, is that something that the zeitgeists of America has changed, and we really want to think about what the impact is? And I think that that's probably true. The ASIS study really changed the fabric of how we think about, our health issues today. And we, some of us do believe, I think some of the evidence shows that — that — the 10 leading causes of death in this country can be attributed to traumatic events experienced in childhood. We also need to talk about it because it's preventable, right?

And we can heal from it. It's not — it's not — it's not carved in stone. And we have to think about it as a right-based model because it asks the right questions. Remember when we used it, and say, "Hey, what's wrong with that kid? Well, what's wrong with you? Why you're behaving that way?" And now we have learned that there are experiences where we have engaged in what can be thought of as maladaptive or functional adaptions to the stressors in our life, right? So, it asks a better question; instead of saying, asking, "What's wrong with you," we've learned to ask, "What's happened to you?"

And we've gone even a step further now. It's not just what's happened to you, but how do you remember it. What meaning do you make of it? That is what becomes important in this conversation. So, what is trauma? So, today I'm going to — this is going to be very broad brush. And so, is there, if you have any interest in going in more depth, they — they'd have my — I believe Head Start has my contact information. Please reach out. But still, we're going to do very brief, broad brush strokes today. So, what is trauma? And I'm sure many of us have already seen and heard the — some definitions.

So, trauma is that, it's really understanding that — that the experience of real or perceived threats, right? Of your safety or the safety of loved ones. That's why exposure to — witnessing domestic violence is so difficult for children, and that causes these — a sense of being overwhelmed, or a sense of terror, helplessness, fear, or horror. So, it's very much about, thinking about what those experience have mean — may mean. How do we make meaning? So, if you think about your family, and you think about your childhood, and think about potentially a family event, let's say a family reunion.

And if some — something tragic happened at that family reunion, all of the people who may have a different response. Some may have a response where there's — what they call post traumatic growth, where they think, "Wow, that was wonderful the way that we were saved and that we — we supported one another, and we helped, and it could have been worse. And God is on our side."

And some can — some of the youth and children might think, "That was really scary," but they've got really good supports in parents and grandparents, or aunties, and uncles. And so, they really come to believe that, "Yes, that was a scary event, but I'm safe now. Everything's OK now. My family is OK, and it'll be fine and I'm going to be OK." But then, there's those children and youth, and some adults, who really perseverate, really are impacted almost negatively, and they don't — and they need extra support. Maybe six weeks out, they're still — say it was boating accident; they're afraid to get in a boat. They don't ...

They can't even watch a boat scene on TV. Whatever the event is, they have a different response to it. And none of us get to say how we respond to those events. So, I think that that's a big message of becoming trauma-informed. We don't get to say, "You know what? That happened to me when I was a kid, and I'm fine. You can get over it." Or, "Do you know I experienced that, too. But after a while, I went back to normal, and it happens to everyone. So, get over it." We don't get to say that.

Everybody has a unique experience. And so, that's how we want to think about traumatic events and the meaning that the individual makes of it. OK. Here's where we talk about ACE's. So, ACE's is the foundational knowledge of research, right, that really began the conversation about how trauma impacts a person's well-being. And we know that, embedded in the research, it's — it's about the experience of the traumatic event that has potential, but we also know that it shows that we have — we have resiliency built into us, right? And again, I would like to say that instead of thinking about the kinds of behaviors, for example, if you, you know, you, in order to cope, very often people are said to engage in maladaptive coping strategies, like, smoking, substance use, which was — we're going to focus on today. Violence. You know? Yeah.

Maybe it's functional adaptation. Because if you think about how we have to cope to survive what — even our 2 and 3 year olds in Head Start — I'm always saying to everyone about any age group, what ... Ask yourself this question when you see particular behaviors that aren't helpful to that individual. What is the function of the behavior? What is behind this behavior? Whether they're 3 or 63, right? Because very often when we are — have experienced, a traumatic event or we're coping with traumatic and stressful environments, we engage in creative and brilliant, but very often personally-costly behaviors. Smoking leads to heart disease, lung disease, early death, right? Overeating, overusing substances. I think about it very often. When I think about a case many years ago when I was doing — doing direct service of two sisters who came to our attention.

I was working in advocacy work at the time, and they came to the attention of the TAU Protection Team because of truancy. And they were 17 and 15, and when we really got down to finding out what was the function of the behavior, why were they missing so much school? We really — we found out that they were living in a household where they were the victims of sexual abuse by a relative, and they learned to protect themselves. And the way that they learned to protect themselves was to stay awake and alert while their perpetrator was awake and alert. Well, sometimes he stayed up 'til 2 or 3 in the morning drinking. So, they stayed up 'til 2 and 3 in the morning, and they were in a household where they had to get themselves up and off to school.

So, if you're 15 and 17, you have to stay awake 'til 3 in the morning, it's unlikely that you're going to get up at 7:30 to get yourself off to school. Creative. Brilliant. But again, personally costly. And that's, as we think about, some of the parents of our Head Start kids who engage in some behaviors that — that we witnessed that seemed to be, you know, not helpful to the well-being of themselves or their family. I want us to think about what's the function of the behavior? What else might be going on? OK. So, one of the things that the ACE's didn't do, it

didn't look at local context, right? It didn't look at necessarily the larger environment, the community, and it didn't look at the social context also, right?

Where there might be structural violence. For example, I would say a perfect example of structural violence is Indian Health Service. So, nationally, Indian Health Service is the primary care provider for the majority of American Indian and Alaska Native people in this country. They are funded at only 50% of need and have been only funded at 50% of need for the last, I don't know, three or four decades. So, structurally, we don't have access as American Indian people to — to really, the kinds of health care that we — that our peers do. OK. So, that's — we have to think about that context. And when we think about that context ... Oh wait, let's go onto ACE's in Indian country. So, would ...

There have been a few studies, not — not many, but this one in particular is very interesting. So, the original ACE study showed that a 63 or almost 64% of Americans — of the Americans in this study had experienced at least one ACE; whereas, in our American Indian study, over 80, 86% of us have experienced at least one event, and four or more, 12% of the general population, and 33% of us have experienced at least one traumatic event. Here are some other studies that have been done.

There's not many. But in this incarcerated, American Indian population ... So, let's see, 81% had experienced at least one, and over half of the incarcerated population had experienced childhood sexual abuse. And in this study of almost 300 youth ages 14 to 24, 40% at least one, and 37% have reported three to six exposures to traumatic events. So, you can see it's pretty prevalent. I think that's the — that's the bad news. The good news is that we must be a particularly resilient people in order to have – be walking around with such high ACE scores and still be so successful in our — in our family, and in our communities.

OK, and the last one, 516 adults in seven tribes in South Dakota, over 60% in at least one, and over 50 — 50% reported household substance abuse issues. So, that's ACE's in this country. I believe there's a question on the side that says, "What is the minimum age of children suffering from PTSD?" Very often ... Oh, I'm trying to speak louder. OK. I keep — I keep, can you hear me now? OK. So ... I believe that we at the National Child Traumatic Stress Network, which is www.nctsn.org, you will find that we have ...

We work with infancy — in infancy. We also have found out from the — from the research that's been done, that very often babies in utero have the same sort of cortisol levels as their moms, and they haven't been born yet, so they — they haven't even experienced their own primary exposure to trauma. They're just — their mom has experienced some exposure to a traumatic event. OK. Moving on. So, we have ...

If you're going to talk about an American Indian community or the population of American Indians, you really have to think about and talk about historical trauma. So, for those of you that haven't heard about historical trauma in American Indian communities, it is a theory that was developed by Maria Yellow Horse Brave Heart, who was looking at the children and — studies of children and grandchildren of Holocaust survivors, from — Jewish Holocaust survivors of World War II.

And those studies were showing that the parents and the grandparents of the survivors of the death camps were having — were experiencing and manifesting the same sort of anxiety, or depression, or PTSD symptoms as their parents, though they were born in the United States and never experienced any — any war — being in war at all. And so, she began to think about how interesting that was — and began to think about her relatives on her reservation in South Dakota, and she began to ask the questions. Could this be something that is relevant for American Indians?

Could this be why we continue to struggle with unemployment, and poverty? We continue — continue to struggle with depression and PTSD and substance use issues. Could that be the explanation? Because we are resilient, strong, intelligent, talented people, why do we continue to struggle? And could this be it? And so, she came out with that theory, and tribal communities really embraced this theory as an explanatory reason why we were experiencing such hardships. So, it does remain a theory, right? And so, Les Whitbeck, and his colleagues wanted to — wanted to sort of quantify ...

Do we really ... Does — does our emotional well-being or our psychological well-being, does it really ... Is it really impacted by the boarding school experience of our great, our grandparents and our great grandparents? Does it really have a connection? And so, they created grief and loss of scale that they — I used to focus groups of elders in, from three different tribal communities. And, as they created this, as they, as the elders talked about the kinds of losses that they think about, right?

So, how frequently do they think about those losses? And so, it, they — the elders themselves said, but it's about the loss of our land, our language, our traditional ways, our family ties, families from reservations to government relocation in the cities around this country, a loss of self-respect, loss of respect by our children and grandchildren for our elders, loss of people through early death, right? And loss — losses from the effects of alcoholism or substance abuse to our people. And so, they created the scale, and then they — so then they asked, "How often do you sit — have these thoughts? Are they intrusive, right?"

So, if you look down to the, the loss of culture, only 10% of this population never thought about the loss of culture. Whereas, you know, let's see where — where – where almost ... So, 25% thinks about the loss of culture daily, right? The loss of language. Almost 30% think about the loss of language daily. So, looking at and thinking about how often they think about it. And so, OK. Yeah. There is culture — there is cultural trauma, and because it's called, very often we call it cultural genocide. It's — it's basically, you know, the wiping out of a culture in order to assimilate a people group.

And that occurred to us. I'll let you address epigenetics and PTSD, OK, Josh? So — so we did think about losing our culture. I thought about the loss of the effects of alcoholism. Almost 30% of every single day think about the impacts of substance abuse on our families. So ... But the question is, OK, you think about it, but does it impact how you feel, right? What are your emotional responses to these losses? And so, it's like sadness or anger. Do you experience rage, or loss of sleep, loss of concentration?

Sometimes people feel sadness or depression when they think about the loss of land, language, culture, and generations of children to boarding school. Or almost 40% think about or feel angry when they think about it; 25% have a lack of — loss of concentration because of it, right? So, it's just very much impacting how we are responding. And it's a layer of grief that American Indian people have that may not be, it may not have impacted the — the well-being of other populations we will be getting to.

So, one of the things that has happened in American Indian communities, and which I think is wonderful, is there's been sort of a renaissance of people embracing their cultural ways, their traditional ways, their ceremonies. And very often, very early in the work that I did with tribes, I would very often hear from tribal leaders, and community members, and elders, we have the answer to everything that's, you know, that we struggle with within the context of our culture, our ceremonies, our language, and our people.

And absolutely, that is a huge piece of the conversation that we have to have when we think about historical trauma and loss. We have to think about our resiliency and think about how we access those strategies in order to support American Indian and Alaska Native families. OK. I see so many questions, Josh. I'm just going to just keep rolling on until ... We've got one more slide and then you can ask one.

So, one of the impacts is — is that if — that in this particular study, people younger than 30 years old had similar historical trauma scores as the elders did, as people over 30 years old, which is fascinating, I think. And also, those people that suffer from substance use disorders seem to be, have a much more emotional response to those trauma and loss in the — in their lives. So Josh, do you have a question that you want to bring forward after this slide?

Dr. Joshua Sparrow: Oh, there are so many great questions. It's, this is a really terrific group of people who are all so passionate and knowledgeable about this topic. I thought maybe we could go back to the experience of young children when a parent or a caregiver has died. That came up a number of times, and I really appreciated your comments that it — it was a process for you to come to recognize, that — that is a form of trauma that is really present in the lives of so many young children and young people, and particularly in Native American communities where there is disproportional lack of access to health care.

And in this current crisis, sadly, we will have more children who will be dealing with the death of parents and other family members, caregivers. So, I wondered if you could just say a little bit about a question that came in earlier about how to help young children when that happens.

Dr. Zimmerman: The only thing that I can describe other than, you know, some actual therapeutic therapies that address grief specifically is in the context of communities and community response. For young children who've lost a caregiver or even their peers, I think that's what we really want to promote in tribal communities is access to cultural ways of grieving, right? So, what does that look like?

Do we help them understand from the context of our cultural belief system, our spiritual belief systems, the meaning of that death, and how do we access it? So, a big part of the conversation very often is, how do we as professionals in these settings, for example, being a Head Start teacher who knows that their 3-year-old’s grandma dies, right? And what kind of role would I

play as a Head Start teacher in order to access ceremonial or ways of grieving? And what's my role in that conversation? Is the family already really involved in — in their traditional ways?

Or are they looking for access, and can I be that person? I think that, the strategy is to help the children understand and remember the good things. Don't remember that, you know, for example, traumatic research says in non-tribal communities to be about it being a very traumatic way the person died. Where I don't know that that's, well, it's accurate for American Indian communities, but helping them rather than remember the tragic way the person died, remember, have ...

Support, good memories about that individual, support the fact that they will feel sadness for a bit, but that there is hope for healing. One of the things that we addressed in tribal communities, that we had to do a cultural adaptation rather quickly on the CBITS model, because one of the strategies for CBITS was if a child talked about a ghost in that context, and for many of us, I'll just talk about the Northern Plains Tribes, we have a belief that our relatives visit us before they go on to eternity, right? That ...

And so, to try to convince a tribal child that ghosts don't exist isn't helpful culturally or spiritually. So, really helping them understand, you know, why grandma visited — is visiting you and then, smudging your bedroom to help her go on her way, and making that child feel safe. I feel like I'm not answering the question the way it was intended, but I — this is what I have. So, but do you have anything to add, Josh?

Dr. Sparrow: No. I — I was thinking that, people who are listening probably want to hear your answer about the cultural ways of dealing with death. I would just add that we've also got a number of questions — I think you mentioned one about how early can PTSD happen in a child. And you talked about at the beginning, at the very beginning. Another question was about whether children remember anything at age 3, and I think the answer is that yes, they do.

And so, in thinking about how children experience death and how we can help them with that, I think you could also address the ways in which children of different ages, including very young children, infants, and toddlers, experience death and how that shows up in their behavior. We've had a lot of questions about that and then how we can help them with those things — thinking about, this developmentally.

Dr. Zimmerman: Right? The ... Yeah. It depends — depending on their, where they are in their development trajectory will have a great impact on how, what their behaviors are that they might exhibit. And so, it's always a good question to ask. Again, repeating myself, I'm asking what the function of the behavior is. I think also reminding ourselves that we used to believe that, you know, babies up to 3 years old were so resilient, and we've come to find that the research has now shown us that they're the most vulnerable at those ages, and not to discount the, some of the grief and loss that they may be experiencing, or gloss over it. OK. Gonna move on. Types ...

So, just talking about the types of trauma. We're not talking about acute trauma. We're not talking about the one-time house fire, the Hurricane Katrina, you know, that sort of thing. We were talking about chronic trauma or the trauma that happens within the context of their households. I think domestic violence, that sort of thing, that's chronic, where it's ongoing. A

complex trauma is early in its onset, and it sort of occurs many levels over the lifespan of the child. And it's very much about the traumas being perpetrators as so ... I hate to say that word by the caregiving system themselves.

So, it's not just that the — that the child is experiencing, witnessing violence, but he's experiencing — witnessing violence with his parents, right? It's not just that they experienced sexual abuse, but it's at the hands of a trusted caregiver that creates some complex outcomes for children and youth. It also greatly impacted, again, is the caregiver response. So, for those children and adolescents who are in homes that don't provide that consistent safety, or comfort and protection, they began to develop ways of coping that allow them to survive, and — and really to function day to day. They may, so for instance, they may be oversensitive to the moods of others.

So, there might be always watching, you know, the adults in whatever context they're in, and surveilling for safety, always surveilling for safety. Might withhold emotions, right, from you or seeming to be overly emotional. And they begin to create an adaptive ways of survival. So, you have to, again, the function of the behavior. What else could it possibly be? We talked about historical trauma, but also, we have to look at and think about the impact of secondary traumatic stress, which is really something that occurs for — oops — families who have, or families, professional caregivers who work in systems where they are working with traumatized students, clients, patients, right?

So, and it's not necessarily that you hear the stories or know the stories of the children that are traumatizing to us necessarily as professionals, it's the behaviors that we — the challenging behaviors that we have to deal with every single day in the context of our classrooms or our clinics, or our communities. OK.

So, here's the range of situations. You can see that the automobiles and life-threatening illnesses and national disasters are above the yellow line, where it's physical or sexual abuse, abandonment, bullying, neglect are below. So, the first are much more about acute and left. The ... Below the yellow line is chronic and complex trauma — traumatic situations. So, for the sake of the conversation here today, and the one that we had it at the opioid conference, I really want us to think about and talk about our — our Head Start students, families, and their primary caregivers, and some of the ways that we can think about and support the moms and the dads who may be struggling with addiction.

Because that seems to be, in my understanding, the most challenging in parenting engagement. So, let's — let's take a look. So, just wanting to let you know that trauma and female addiction does have a correlation that, one of the first studies on trauma and female addiction, 74% of the women had experienced sexual abuse. Women who have traumatic childhoods are five times more likely to use drugs and twice as likely to abuse other substances, and as many as four out of five women seeking treatment for substance use report a lifetime history of sexual assault, physical assault, or both.

So again, 50 to 80% of women diagnosed with serious mental illness had been sexually abused. Ninety-nine percent of — up to 99% of some women in this particular study were sexually abused; 90% of women with alcoholism were sexually abused, and 92% of incarcerated girls

report sexual, physical, or severe emotional abuse. And the news isn't much better for American Indians. So Josh, I'm not sure how to respond to the side questions. Do you want to — want me to address them or show ... Can we talk about it at the end? On the COVID-related questions?

Dr. Sparrow: Well, I'm collecting COVID-related questions and I just want to share that that is on the minds of so many of our participants. So, you have a heads up that they're there and we can come to them whenever you're ready, and certainly, at the end.

Dr. Zimmerman: OK. Great. I think one of the conversations about COVID and the social isolation that we have to do, the social distancing, is that the rates of and the risks of increased child abuse, child sexual abuse, increased risk of domestic violence — victimization from domestic violence — goes way up because of the social isolation. And I think that we're going to have to have a way of responding, for — to — to the parents and other, and the children once we're not once COVID-19 is under control. May that come very soon. So again, Native women exposed to violence. You can see that the rates are much higher than the general population. Same thing with the ...

Oh. I guess I didn't, [Inaudible] later. So, NIH has some studies about the percentage of American Indian respondents had been victims of rape or sexual assault — 96% in one study; intimate partner violence, almost 40% in another study. And there is one particular study that has shown that American Indian women experienced physical assault and an injury much at — much more intense or higher rates then their non-Native peers, and it's very much associated with American Indian women will not reach out, will not call 911 until something is broken or bleeding, or very often, non-Native women will reach out when there's just verbal threat, so that's the bad news.

The bad news is also that our children are really witnessing really high rates and very violent rates of domestic violence. Native men aren't exempt. You can see that between the Native and non-Native, that there are much higher rates of exposure to violence and different types of violence. So, this is what we know about trauma. It's very common, right? Almost 90% of us have experienced at least one traumatic event, and on average, nearly — no, we experience at least five traumatic events in our lifetime, and those events can impact our well-being no matter, whether it's health, our physical health, or mental health, or relationships. Families, employment, everything.

When I was asked — when — as you heard from the introduction, I was on the American Indian and Alaska Native Advisory Committee for children exposed to violence, and one of the, we held hearings, five hearings across the nation and invited people to come and provide statements about the impact of exposure to violence on the well-being of American Indian-Alaskan Native children, and Mato Standing High the then attorney general of the Standing Rock Sioux Tribe made this statement and he said, "It's not who's been exposed to violence in our communities, it's who hasn't been."

That's more of a question. And so, just without trying to — as a tribal member, I don't want to pathologize American Indian people in general, or my own people in particular, but just knowing that there are very high rates in Indian country, of exposure to violence and traumatic

events, grief, and loss. So, the reason that we're really talking about trauma in this context is it's really looking at trauma as a gateway drug. I love this quote by Russell Brand. "Cannabis isn't the gateway; alcoholism isn't; nicotine, caffeine. Trauma is the gateway to drug abuse." Right?

So, that is a big piece of the, some of the functioning — functional ways of coping that our parents and our grandparents have taken up in order to be able to just cope with their own trauma histories. So, let's think about those parents of the — of the kids that were, their parents and grandparents. And when I say parents, I mean caregivers, whether that's an auntie or a foster parent or an adoptive parent or — right?

So, let's think about those — those that struggle with substance use issues. So, parent-child relationships are very much impacted by the parents' trauma and their addiction. So, when you're trying to do family and parent engagement ... We're going to — So yes, we're going to talk about — thank you. We're going to talk about the impact on parents, and we're going to give strategies for Head Start professionals to be able to support parents if — if they so choose to with their substance use issues.

So, remember — reminding ourselves as we think about our parents, that very often — that there's shame, guilt, and remorse for their behaviors while under the influence, behaviors that, you know, created chaos for themselves, but — but mostly about their children. Their memories can be stimulated by just having a child of a particular age.

I remember working with a woman once who had done great work in healing from her childhood sexual abuse. And she came to my office one day and said that her daughter had turned 5 the week before, and what was so notable about that back was the fact that her sexual abuse began when she turned 5 and now her daughter had turned 5 and she remembered that's when it started. But it was all — it was — it was healing for her because she said, "You know, there's nothing provocative or sexy about a 5 year old." And I said, "No, there's not." Somewhere inside of her, the residuals of her own guilt about what she may have done to cause the sexual abuse, no matter how healed she was, it still was lingering, and that was a very healing moment for her.

Very often, our parents who suffered from addictions aren't, don't have really good examples of parenting models. I think the biggest, the conversation around historical trauma for a lot of American Indian researchers and community members as they think about the impacts of historical trauma, is the boarding school experience. When the traditional nurturing, healthy parenting ways of the tribe or family and community were removed, and the children were removed from those safe environments and placed in boarding schools, where they are raised under, you know, sort of a military way — a strict military upbringing where they weren't nurtured, where they weren't — their needs weren't, emotional needs, and psychological needs, and fiscal needs are very often not being met, and generations returning home without then the knowledge of, or having good parenting models, and they all — for themselves, right?

So, because it was removed from them, so they often engage in coercive or punitive parenting. I'm sure you've witnessed that. Because of their own trauma history, their abilities to regulate their own emotions, isn't there. And so, you know, a triggered parent, a triggered adult can't sooth a triggered child, right? If this doesn't seem to be so — I guess the question on how we

support resiliency, it really is very much about helping parents understand and engage in some self-soothing, mindfulness, meditation, deep breathing, self-soothing ways.

The same way that you teach your 3 and 4 year olds or earlier in, sort of managing their emotions. And very often parents have made some really poor judgments about the safety of their children. They have allowed them to go with unsafe relatives. They've left them alone, right? And now they're coming to the realization of what they've done. If they're trying, you know, to get sober — clean and sober. And so, I think the big piece of the conversation is, what is my role for a parent who's addicted and their want — and they're in recovery, or they want to go into recovery, what do I – what do they need that I can provide for them?

So, here's a big piece. Understanding and knowing that very often, particularly moms, we need to retain out just a hint of denial, right? To protect their own self — fragile self-image, especially early in recovery and not being too harsh or hard on a parent, especially in early recovery. They have to come to the place where they understand that some of their behaviors are really just the consequences of their addiction, they are not evil people, right? That their addiction, their trauma, and there are ways of coping, their attempt to survive, and some of their behaviors weren't deliberate. It was just them trying to cope.

Very often we don't want to look at our own child — childhoods if they were particularly traumatic. And we have to really help parents develop a sense of self empathy, right? We all struggle with something and having the, to be being trauma-informed, like a universal strategy if you want to get technical — it's really just to be helping them, being empathetic to their needs and helping them develop some self-empathy and self-forgiveness, because they'll need it.

'Cause they're going to have to take an honest look at the impact that their substance use had on their children, and they're going to have to learn how to parent differently, and that's not easy in recovery. So, during recovery — during recovery it may be difficult. You may notice that Head Start parent of a 3 or 4 year olds who doesn't seem to be able to tolerate the child's anxiety, or their aggression, or even their sadness. They may be reactive and punitive in their disciplining of the child in your presence.

That's a good opportunity to provide a way to open the door for conversation about what a different kind of response might mean. Again, that the child may serve as a reminder or a trigger, you know, to their — to their own helplessness in their — and their own neediness. And it may be that they don't do well with boys because they're, you know, boy the gender or the age of the child, as I already gave an example of.

So ... Also, what very often happens early in recovery is, OK, mom — mom is clean and sober now, and she's home with those kids, but she still may not be parenting, right? She's still may be isolating herself in the back bedroom because, you know, maybe not drinking, that she sleeps. She doesn't trust herself to be, you know, to not be punitive with kids. So, she's — she doesn't trust herself and she distanced herself from her own children.

And ... Any — any time the — Head Start parent can also really be triggered by the responses of Head Start. Yeah? Because they already have a belief that no one cares about them or that nobody can help in those early stages. So, being really empathetic, really thoughtful, really

encouraging becomes an important piece for Head Start staff in order to support parents to help them continue on their journey to recovery. But also knowing that, you know, you may have — be well-intentioned, that this is what I say often to teachers with children. They are — they know they're safe; they know they are a safe adults.

They know they care about this child, but not understanding that a child is always surveilling for safety, right? And even though they're well intentioned, the children may not respond to their well-intended language or body language or verbal language. And so, we can very often, it's the same way with parents. Trauma impacts the way that they engage in healthy relationships or especially, responses to services.

So, here's the question that I want you guys to think about, is think about an example from your own personal or professional experience when you reached out to a parent in an empathetic, thoughtful way, and it just seemed to backfire, right? They didn't seem to respond at all. In fact, they seem to become angry or didn't answer you, or quickly left, right? Or they dropped out of the parent group, or whatever that might look like. And then, very often if the trauma has occurred in those service contexts whether it's primary care or a school setting. Maybe they didn't have a good experience with schools and Head Start is an extension of that negative experience.

So again, think about your own experience with those parents and how Head Start, the fact that — just Head Start itself may be a trigger. So, how do we, again, here it is again, listen, reiterate, supports needed for recovery. Parents may need to retain that denial. They may — may need to develop understanding of the behaviors. They may need to examine their own childhoods and develop that self-empathy, right? They have to look honestly at the impact, and they need to learn and find support for their ability to parent differently I think, Josh, here's another space, place where we were going to pause for questions or comments. Hello?

Dr. Sparrow: Hi. There are so many, really important questions here. There were a number about COVID-19, which we might save until the end. Obviously, that is on everybody's mind, and I'll just say for the moment that my friend, Jackie Hate at Port Gamble [Inaudible] has put in the chat that there is a social distance pow wow happening right now with dance off. And there were 151,000 people on Facebook.

So, I just thought I would mention that now. And then, there are a number of questions about parents. One was asking, or more about how to build parent resilience. And then, there was a specific question that is related to COVID-19. What can parents do to improve their mental wellness during this confinement and jobless period of time?

Dr. Zimmerman: Wow.

Dr. Sparrow: They're not easy questions, Marilyn. Sorry.

Dr. Zimmerman: They are not.

Dr. Sparrow: They're tough. They're really important. Yeah. They're really ...

Dr. Zimmerman: So, I think that, yeah, the, for example, the — the virtual pow wow that's happening. There are virtual support group meetings happening, being able to help parents'

access those or find those. That's going to be really important. And depending on their access to computers, whether they are able to own one themselves or if they have the internet even.

But for those that do really promoting, reaching, thinking about, and accessing many, many free resources online around meditation and mindfulness, and prayer, and engaging in those sorts of — of activities, really being mindful that — I see a lot on Facebook, or they're being mindful of look, don't push your kid, right, to try to get all of the assignments done. Just be together. Just, you know, relax, do all you can to take care of each other. And I think that also thinking about reaching out to, I think most communities, I don't know if they call it two on one, reaching out for resources within the community, for food and for utilities, and for rent is going to be critical for them.

And — and as, maybe as Head Start professionals trying to get the word out about those resources, finding – finding and getting the word out to those resources. I know that, for instance, the Tribal Law and Policy Institute, The National Congress of the American Indian — we have some resources where it's very — it's very much about, and totally related to COVID-19, right? How do you cope? How do you — how do you help your child? How to talk to your child about COVID-19 and the impacts of it? They are accessible. So, it's www.tlpi.org. From my perspective, that's one of the best sites to go to, the Tribal Law and Policy Institute, to access COVID-19 resources.

Dr. Sparrow: So, there were a, thank you, a number of questions about the challenge of opening up conversation with parents and other family member caregivers who, for one reason or another are not, engaging in conversations with family service workers, or with teachers, or other Head Start staff. There is one about the stereotypical tough shell. And then there's another about, you know, how long do we keep on calling if they don't answer? And so, I wondered if you could address this challenge of reconnecting when the conversations are difficult to continue.

And — and I — and I thought maybe you might connect this to another important question, which is how can we help parents understand and agree to services, such as therapy, to help children who are going through grief? Some parents are in denial, or feel their child is too young. So, that's one question. So, parents who have their own idea about what their child needs, that's different than what the teacher family service workers idea might be. And then there's another question, which is, we're all here because we recognize the need to address trauma because we see it every day.

How you build resilience in parents? We're supporting their children who are likely experiencing their own trauma. So, I guess I'm asking you to think about — there are parents who have their own trauma, right? And how you build resilience with those parents? There are parents who are seeing their children's trauma, but having trouble really facing it, or accepting what you might think would help now. And then, there are all of these questions about difficult conversations.

And I guess I'm suggesting that there were some connections between parents dealing with their own trauma, parents trying to deal with understanding their children who have

experienced trauma, and then having trouble getting into those conversations or staying in those conversations with family service workers, teachers, and other Head Start staff.

Dr. Zimmerman: Though — all really good questions, and all really difficult to answer. I think that, the ... So, showing empathy being, you know, the greeter for Head Start when moms and dads, and grandmas and grandpas, and aunties dropped the little ones off, if they're not riding the bus, right. Or even the bus driver, as he pulls up to pick up the little ones and how he interacts with the parents has to be kind and thoughtful and empathetic.

I can remember listening to a presentation on trauma-informed agencies, and the person said — she, Mark Wong, she's the head of Dances, Trauma — Trauma and Recovery division, and she just said, you know, it starts with the receptionist, who knows what it takes for that individual to drive into that parking lot and come through those doors. And just remembering what it takes for those parents to walk out of their house and put their little one on that bus, or what it takes for that parent who's struggling to bring that little one into your building, right? Just remembering that that's a huge start. It's universal.

Very often, I think that during conversations when you're developing a parent group to have training on the impacts of trauma, on well-being, and talk about it from the perspective of their own trauma, what they may have experienced as adults, which allows them to understand that you have empathy for them and their histories. So, to better support their ability to have empathy for their children. I think a lot of — just a lot of resources to the impacts of trauma on different developmental ages.

And how to talk to their children. So, here's another resource, www.nctsn.org. It stands for the National Child Traumatic Stress Network.org. There's a whole bunch a free handouts for parents, from hurricanes to car wrecks, to sexual abuse on helping parents develop language to support their children. I think that that approach to the parents who does not necessarily believe or think or want their child to go to therapy. It might be self-protective. They might be worried about what the child will disclose during therapy, right?

That might not — that might threaten their custody. So, just helping that parent be able to understand that grief and loss, the impact, and what it can look like in some of the language that you can be involved in, and you as staff supporting that student, that little Head Start person as they are experiencing that grief. There's no, I wish I could say, you know, "Oh, it's just this. Go do. Go here." There's no silver bullet, so to speak. There's no one way. It's very much about relationships, developing relationships. In fact, we often say that the best evidence-based treatment for trauma is relationship, healthy, nurturing, supportive, empathetic relationships. I feel inadequate to answer those questions, but that's what I have.

Dr. Sparrow: I think I'm — probably, a lot of us are, feeling that way, as well, Marilyn, and I appreciate your speaking to that and all we can do, is what we can do. I would just add that for the question about the parent who may be quote unquote in denial. I think one of the hard — one of the hardest things for parents to, and this is about whether it's, you know, a difficult behavior in the classroom that is really hard for teachers to understand or manage, or one at home, or both, whether it's related to this current COVID-19 pandemic or to an earlier trauma.

You know, all parents want to do well by their children and all parents want to see their children do well, and especially if parents have their own history of trauma. You know, one of their big hopes and dreams is that they can protect their child from having to experience what they experienced.

And so, I think when approaching a parent about the possibility that a difficult behavior is related to a trauma, to understand how much it matters to the parent to feel that they can help their child heal and how hard it is to say, yes, their child is suffering. The other, I think part of the answer to that question is cannot start with our own theories about the behavior being related to the trauma. Instead, to have a conversation about the behaviors without judging them or interpreting him, but just to — to talk together with a parent about, you know, what do you notice your child doing?

If I tell you what I see the child doing so that you create a shared understanding of what you're seeing, and then that begins to create some safe to support, "Well, what do you think the child's trying to tell us with their behavior?" Because behavior always has a purpose. And then, I think for the question about the parents who may not want to be in conversation, it's similar, you know, in both instances it's about protecting, you know, protecting the really hard, painful feelings.

And I think to honor, as I think you said earlier, Marilyn, about adaptive ways of coping, to respect the people need to do that and to reassure them that as long as there are some things that it is protective to not talk about that, we will honor those things and to really look for safer, more neutral topics that people will be more ready to engage in. And that's where you create the safety and trust so that eventually you can move into things that may be harder. And again, I know it's easy to say, and hard to do. And I share your feeling of inadequacy about how to respond to these really important and pressing questions.

Dr. Zimmerman: And it is very much as I said, relationship is the best evidence-based trauma treatment model there is. And developing those relationships means developing that trust, you know, with the caregiver in order to be able to have those kinds of conversations, or even, you know, like very often I've watched, I've witnessed it, where parents will go and take the child in and — and quickly eject out of the building. Being able to get to the place where you can even have a conversation. It's very much about building that relationship. OK. So, let's — let's move on. I hate to — I just see that we don't have much time left.

Dr. Sparrow: So, let me just — let me just prepare you before you do that, that we also want to talk about teachers and [Inaudible] other staff who are very much like the family [Inaudible] trauma. So, just ... so that you can begin to think about that as we're rounding the bench here.

Dr. Zimmerman: Great. Oh, I like it very much. Because that, you know, that's a part of the conversation that — I'm so glad that someone brought it up — that we really do have to address. And sometimes I think that that's where I — I think about, and talk about or hope for when I'm talking in settings where we have to engage families is — is as professional caregivers, we really do have to look at, examine, and address our own histories, right? Hurting people hurt people, as the saying goes, and so, it's very much about how — how can we address that with

our — with our peers, with our — with our colleagues. How do we become trauma informed is very much about how do we support one another with healing from our own histories?

And that might be the beginning of the conversation for an agency, right? Or a program, that — that's how it starts. And maybe that creates empathy from parents. Like, "We've been looking at this for ourselves and here's what — here's what we have, you know, here's some realities that we've come up with." Or, "Here's some solutions or supports that we have." So yes, very much about that. Because we only have 15 minutes. Let's see. I'll just go quickly through some of these slides.

So, just reminding ourselves that American Indian people are very resilient. We — we have a lot of optimism often during our adversity, and we have lots of empathy. We have humor and our community strengths are there to support us, and — and it's important. So OK, here we go. So, I always do want to talk about trauma goggles. How do you know you're trauma-informed? You again, you are cognizant of, and they're quick to think, what is the function of this behavior? Whether it's your student, or your colleague or your parents or your caregiver. So, it's really putting on those trauma goggles and being able to automatically go into that mindset. So, there's some key assumptions about trauma-informed.

It's really — what we're doing today, it's really realizing at the beginning that it is widespread, that it is impacting our communities, and it does impact, but there are ways to recover. It's recognizing what — what those behaviors look like and mean for everyone, and then responding with some integrative knowledge about trauma within your own policies. For example, do you — can you — do you have to turn — here's what ...

My schools is a perfect example. If a child is late until 10 a.m., they're counted late for the day. Well, children who experienced a lot of trauma are often late. Can we change that policy so that they don't have missed days and then they're in danger of losing all of their credits? Are there ways that we can respond to it, family needs that aren't punitive, that, you know, we can better support? And then the big piece is resisting re-traumatization within the context of our agency or program.

And so, how do we do that? So again, recognizing some triggers. What it looks like, what are some of the languages and behaviors that children have experienced that — that we can make a difference in — in the way that we engage with our children and our families? Do we have any trauma, evidence-based trauma models that we can use? What are our policies around that that promote culturally-based beliefs about resilience and recovery and healing that always getting that message of hope. And then systems response, using the sort of universal, and that's very much putting those trauma goggles on.

You can do — you can provide evidence-based trauma treatment models if you have a strong referral system to providers that have, that employ those therapeutic models. But if you don't, you have to use much more universal strategies that ... And it's just — it's good for everyone. So, let's enhance resilience. So again, promoting those relationships with competent, caring adults. Not — not just from, for the students to the caring adults in the building or in the program, but also promoting those relationships with the parents, you know, promoting the

parents programming, promoting the parent's organizations and coming to them, and making it as non-threatening as possible. Facilitating [Inaudible] secure figures.

Really making sure that your support staff at Head Start are really empathetic, kind, and not punitive in any way. What's it look like to focus, support — the function of a parent during a particular crisis like COVID or a family crisis, like the potential for homelessness or the death of a loved one? Again, really fostering among yourselves quality relationships with your staff and quality relationships with the parents.

And fostering school bonding and engagement, again, is very much about relationship, relationship, relationship. 3 and 4 year olds, nurturing their brain development no matter what, even if they have trauma histories and they engage in some challenging behaviors, really understanding that you are, that that's your role is to nurture that. And — and you, we can teach our children our little ones, some self-regulation skills. And maybe helping, you know, part of the parents — parent group meeting is teaching parents some self-regulation skills that they can see and that they can, you use to support the children to self-regulate. And it also helps them understand they need to self-regulate, understanding and relating to, and providing opportunities to, for students or parents to develop their own talents.

And making, especially for the parents, making what — what's meaningful about this action. Letting them know the why behind why we need you here and making it meaningful for them. In tribal communities, always looking at the culture — cultural traditions, and ceremonies and ways to support the parents and connect them with the spiritual and cultural leaders in their community, and then again, addressing our own secondary traumatic stress, and I think that's where we can begin the conversation with our peers to address their own trauma histories is maybe framing it in the context of let's all learn how to understand and practice good behaviors to support our secondary traumatic stress. Remembering that trauma and recovery means for the parents that changes in roles and relationships happen when they were using, and it will be different now that they've quit.

Again, thinking about what stimulates their guilt and remorse, their fear and loss, and what kind of triggers may they be experiencing. And remind — and then reminding yourself that when you don't, we use substances to cover our feelings and now it's time to feel the feelings without those substances. And that requires support and maintaining at length, all year long, that empathy for the parents. How many times do you call? You call until you reach somebody. You call until the school year is over. You keep reaching out. I don't think you give up. So, just understanding that trauma work isn't just me doing my thing within the context of a classroom, it's very much a team effort.

It's about us addressing our own trauma history. It's about us addressing our secondary traumatic stress needs. It's very much bound in culture. So, understanding the resilience of a people group have experienced the collective grief and loss of land culture, language, spirituality, parenting models. Again, focusing on building resiliency so that we don't focus on the pathology of our kids, or our families. And it really, honestly, there is no single way to address a parent.

There's no single way of creating an intervention for a child. It's multifaceted and it's a multifaceted lens. It's those trauma goggles through which we really view behaviors of our students, our colleagues, and our parents. So finally, we really can't ignore the implications of trauma. Well, for children and families, it's a huge cost to quality of life. Evidence-based interventions do make a difference. We really believe tribes make a difference. And absolutely know that you all that are listening to this presentation, that are involved in Head Start in any capacity — whether you are a janitor, a cook, a teacher, a parent, a grandparent, a relative — that you make a difference in the lives of the children. And we want to continue to provide really good support for you all as you do this really good work. OK. I think we've got a couple more minutes now. Sangeeta do I turn it over to you, or do we open it up for questions now again, or comments?

Sangeeta: Well, Josh was there one last question that maybe you wanted to — to ask Marilyn, based on what's coming in.

Dr. Sparrow: Yeah. I, first of all, I just want to point out that there are lots of helpful and hopeful suggestions that lots of people are offering each other on the chat about how to work with families during this difficult time where some — where access to families is — is, may only be through phone or texts or Facebook. So, just to point out that there — there are a lot of hopeful and helpful suggestions on this chat. And then, there were a lot of questions about looking beyond COVID-19, and — and maybe that would be a good place for us to wrap up is what Marilyn, what would you — what would you think we should be ready for when this is over?

And you know, one question was, will there be a dramatic rise in trauma afterwards? Will parents, after this is over, judge themselves harshly about, you know, how they handle having all their kids at home during all this time? How can we be proactive and best support families when – when it's time to transition back to being back in centers again?

Dr. Zimmerman: Yeah. I'm thinking that, I think we should probably, again, a fearing to pathologizing, but we should expect that the maltreatment or some exposure to domestic violence, but those rates will go up. And so, be expecting that when the children and families come back to the classroom, that you will have to deal with that in that context. And so, you, to be focused on empathy and understanding, and putting those trauma goggles on are going to be really important. I think that one of the things that I want to tell, just end with a story. We were invited to New Orleans after Katrina and that ...

So, this horrific hurricane displaced families, right? It was a year before people came back to normal, so to speak, and even then, it wasn't normal. And to understand that COVID-19 is going — is something like that. It is like a hurricane in that it's — it has a beginning and an end, and it's having an impact right now on our well-being. But five years afterwards, we were — we had gone back year after year. The youth — the children and the youth were saying at the — the parents, the adults were still talking about the impact of Katrina on their psychological and emotional well-being, and spiritual well-being, but the youth were telling us that the — the hurricane wasn't what was bothering them the most. It was once again, being exposed to the community and family violence.

And how did you cope with the grief and loss, right, of friendships and relationships. So, to just remind ourselves that this is a moment in time that we will go back to still needing to have empathy and understanding for the day-to-day lives of our students and our families. And how the — how COVID-19 exacerbated some of the — some of their lives, but that no matter what, we're still thinking about real life, everyday life in — in — in our communities, and the everyday life of our students. And to just understand that trauma-informed approaches, trauma goggles is all very much needed to be sustained throughout your professional career, if that makes sense.

Sangeeta: Thank you so much, Marilyn, and thank you to Josh as well. This has been a fantastic webinar. Really engaging. Love all the comments. Love the uplifting thoughts. You know, Head Start Heals is all about how Head Start is in this great position to actually make a difference in the lives of children and families. We are comprehensive in nature. We have family engagement at the cornerstone of the work that we do. And so, we are in the right place at the right time to make a big difference. We are going to continue with the campaign for at least the next month.

We're going to do our best to answer so many of the great questions that are coming through. We really encourage you to get onto the MyPeers community. We have a community now just dedicated to mental health. You can find that and add into there. We encourage you all to have these types of conversations there. Our National Center on Early Childhood Health and Wellness will be able to send in more resources for you there. So, it's just kind of a nice place to be if you want to be continuing the discussions, types of discussions that we had here today. And just to know that we do have some events coming up.

We have one tomorrow at 1 p.m. Eastern Standard Time. I'm going to be joined by Neil Horn from the National Center for Early Childhood Health and Wellness, where we're going to be having a Q&A discussion around mental health consultation. So basically, we're bringing together questions that we're hearing from you all, often about mental health consultation, and we will be addressing kind of what mental health consultation can look like and mean in the current COVID time as well.

And then coming soon, we're going to be having webinars and office hours related to trauma-informed care in classroom settings, discussion of trauma-informed care in Migrant Seasonal Head Start, as well as trauma and adult mental health. So, please stay tuned for that. You can send any emails you have related to trauma to trauma@eclkc.info and it will — it will get to me, as well as our team. And here's the website on mental health as well. So, we hope you enjoy the rest of your day. Take care of yourself, be well, and we'll be with you again soon. Thank you so much.