

[Music]

Ivette:

Hello, I'm Ivette Torres and welcome to another edition of the *Road to Recovery*. Today we'll be talking about *Overcoming Trauma and Violence, the Power of Resiliency*. Joining us in our panel today are Sis Wenger, President and CEO of the National Association for Children of Alcoholics, Kensington, Maryland; Art Romero, Clinical Director, A New Awakening Clinic, Rio Rancho, New Mexico; Cheryl Sharp, Senior Advisor for Trauma-informed Services at the National Council for Behavioral Health, Washington, D.C.; Dr. Larke Nahme Huang, Senior Advisor in the Administrator's Office of Policy, Planning and Innovation, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Rockville, Maryland. Larke, why is it important to talk about trauma when addressing behavioral health issues?

Larke:

Ivette, that's a great question. We know now from research, from clinical practice, from experiences and voices of people who are survivors of trauma that trauma plays a significant role in contributing to mental health issues, substance use issues, and related health concerns as well. I have to say that years ago when I worked in psychiatric crisis units, we never asked about trauma and it just is mind boggling to me now that we didn't think about the role that trauma played in the people who are coming in in various crisis situations. So and I have to actually attribute to Sis Wenger that Sis brought the Adverse Childhood Experiences study to all of us at SAMHSA. And that's when we really began to look at what that major research study was saying about people who had been exposed to early adverse experiences in their lives and their families, that they showed up later in different kinds of behavioral health issues, mental health issues, substance use, as well as other physical health conditions. So now we recognize this and we think it's critical to take into consideration people's trauma exposures, histories as we provide the best kinds of care we can.

Ivette:

So Sis, let's follow that. How are mental and substance use disorders a risk factor for trauma?

Sis:

Both put people in a vulnerable position. They are not able to totally control their lives whether it's mental illness or addiction that's driving them, and if they have either in the family, if I'm a ten-year-old child and my mom has mental illness or addiction, or both, there is a tremendous amount of emotional trauma that is wasted on the child in circumstances like that, which sets them up for trying to live an abnormal life. They work very hard to survive in the hostile environment in which they are growing up—emotionally hostile at least and oftentimes physically hostile. And as they get older, why wouldn't they find a drink or a pill soothing when they're trying to calm the devils in their head. But they do a great

job of surviving as children and the stress of that survival process creates more emotional trauma for them, and when they become adults they tend to still use the survival skills that they used as children to survive, and that gets in their way of having a balanced healthy adult life and then we run into some of the problems that Larke was discussing. I can remember a nurse colleague of mine in Michigan years ago who was a psychiatric nurse and she was tending to a client and she pulled the records out, thought something seemed odd and this client, this woman, had had shock treatments one after another after another, and she asked her a few questions and she said, you know, I think you need to go to an Ala-non meeting. And she literally had had a traumatic childhood in an alcoholic family and that was really what was driving what was going on. So I think it just continues the impact.

Ivette:

So Cheryl, let's talk about the definition of trauma. What is trauma in its various forms and I know clinically others refer to complex trauma and there's of course trauma from violence. Can you go into a little bit in terms of defining these terms?

Cheryl:

Thank you, Ivette. So when I think of trauma, the first thing I think is that it's an individual's experience of an event and how it manifests itself in that individual's experience, but it's a series of events that affect a person's capacity to cope, and when I think of trauma—I believe Larke was talking about the ACE study and Sis' introduction to SAMHSA—when we look at the ACE study, we're really only looking at ten events and what we know is that trauma can be whatever the person describes as the traumatic experience for that particular person. We think about complex trauma as something that happens over and over and over again, and very often it is with those most intimate relationships whether it's in a domestic violence situation or situations where one person has control over the other, or in a parental relationship when it becomes complex, it's happening over and over and over again to that person.

Ivette:

And of course, the trauma from violence would be the physical violence or the trauma perpetrated against one's own physical body and what someone may feel.

Cheryl:

And the witnessing of violence.

Ivette:

And, Art, what are the different types of trauma and violence? Let's talk specifically, we talk more broadly about defining what trauma is, so in terms of children, in terms of adults, what would children be experiencing, what would

adults be experiencing in your clinical career, tell us a little bit about what you have seen.

Art:

Sure. Children experience different kinds of trauma. Sometimes it's directly from the parents, sometimes it's witnessing maybe violence between the parents, sometimes it can come from bullying at school, for instance. I had a series, I want to say within a week, where I had three young girls that came in separately, and it was interesting, they were each nine years old and they had had bullying going on at school and they were suicidal. And that's why the guidance counselor, the counselor at school had sent them to me. What I found out going through the complex trauma was that they were already set up for trauma because they had already experienced trauma at home. All three of them had addict—either one or both parents. And so there's so many different ways. Also neglect. You know, some kids are neglected because maybe the parents are involved in addiction or something else or the parents have their own trauma that they're dealing with, their own PTSD or whatever it is, their own mental health disorders, so they get neglected. And then there's also the idea that going back to what Sis was talking about with children of alcoholics, you know, if you're a child of an alcoholic and you see your parent using or drinking or whatever it is, you don't trust their parenting skills. You think is this person able to be my parent, and if you grow up like that, then of course you're setting yourself up for any kind of high risk behavior because you feel like you have to step in and take that over and parent yourself, and you don't know how to parent yourself. So there's so many ways that kids experience trauma.

Ivette:

And, Cheryl, I saw you nodding your head as Art was speaking.

Cheryl:

Yes. So what I wanted to tag on to what Art was saying is there is sins of omission and there's also sins of co-mission and the sins of co-mission are those very obvious things like the physical abuse and the violence in the home, but there's also in that neglect piece, there's emotional neglect and that's something that's very hard for people to kind of tap into when they're thinking about the experiences of trauma and especially when we're looking at families who have been cut off because of addiction. I mean people just shut down and therefore the child picks up that sense of neglect and carries that into adulthood.

Ivette:

So that could be considered when a parent really doesn't parent a child it's really a very traumatic sense for the child because they don't know who to look up to and they really have no sound basis for their development.

Cheryl:

The withholding of affection, the withholding of connection, the withholding of basic teaching of what it's like to be a parent and how the child can interact in the world.

Ivette:

Very good. So I want to go back to Larke and have her talk about the key issues now concerning trauma and violence.

Larke:

I'll build on what Cheryl and Art were saying about the types of traumatic events that occur in people's lives, various types of reactions. Trauma is becoming a very critical concept for a lot of people and we look at it in many different ways, it's explained in different ways and so at SAMHSA we tried to gather information and gather experts to help us think what's a good framework for thinking about what trauma is. So we came up with this concept of the three E's of trauma where there is an event or events or a set of circumstances that lead to an experience that is in some way felt by the individuals as life threatening or physically threatening, psychologically threatening, but a very strong sense of life threatening. And that leads to a set of effects, so that's the third E. So it's an Event, a sense of Experience in that event and then an Effect that is long lasting in duration and the effect may not even occur immediately. Someone may not label an effect with that event immediately. It may happen years down the road.

Ivette: Or it may be precipitated by another event.

Larke:

Exactly. It could happen immediately or it could happen five, ten, fifteen years later that the connection gets made. So we didn't want to just do a checklist of these are all the types of traumatic events that lead to some of the health concerns we're focusing on, but that becomes almost a very much individualized experience or it could also be considered a group experience.

Ivette:

And when we come back, I want to continue to talk about that formula that Larke has just given us and expand on it. We'll be right back.

[Music]

Pamela Hyde:

I think people who have experienced trauma need to go to and see a person or provider who has some sense of what trauma is about and knows how to do trauma-informed care. So SAMHSA has been working a lot on trying to have our behavioral health providers understand trauma, know that you need to ask about it, know that you need to have a sensitivity to it, allow individuals to talk about it, and not necessarily fix it, but also to try to do the right kind of assessment for that trauma and to be sensitive to the trauma-informed care. There's obviously

trauma-specific approaches for dealing with things like domestic violence or bullying as a child or those kinds of issues, or even seeing violence in the community. As importantly I think is that all behavioral health providers need to be trauma-informed in the way that they design their programs.

Male VO:

For those with mental or substance use disorders, what does recovery look like? It's a transformation. It's a supporting hand. It's new beginnings. When does recovery start? It starts when you ask for help and support. Join the Voices for Recovery. Speak up. Reach out.

Female VO:

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[Music]

Cheryl:

I just want to share a little bit about why the work around trauma—why I'm so passionate about this work. As a person with lived experience as a trauma survivor, someone who experienced medical trauma as a young child and then also living in the home with a mother who was severely ill throughout most of my childhood. It had a tremendous impact on me. Early in my teen years I started having suicidal ideation and by the time I was 24 I'd attempted suicide nine times. I've also been very involved with excessive use of alcohol and drugs which had a huge impact on me and what I've recognized as I begin my recovery journey was that what happened to me was the reason why I used those coping strategies that were so unhealthy for me. And one of the things that also happened is that as I begin my recovery journey, there were still issues that were unaddressed. The suicidal thinking was still there and what happened was I ultimately had the opportunity to go through a trauma program. And by doing that and being supported in such a caring environment, it absolutely shifted and changed my view and my vision of what my life could be. And so the work that I do at the National Council is all about supporting providers and peers to bring out the best of who we are and to really bring the message that there is hope, there is recovery and that healing is possible for everyone.

Ivette:

So Larke, we were talking earlier about the framework that SAMHSA has put together. Do you want to expand on that just a little bit?

Larke:

Sure. So Ivette, we have more research methodologies now that help us understand some of the underlying neurobiological issues around trauma. So before, we were not able to really understand what's going on neuro-

developmentally with a person who is exposed to traumatic events or traumatic stressors. Just like we know addictions now really leads to brain changes, so we know that trauma does as well. And so as we understand more about that, we can understand why we get some kinds of the responses, why we get posttraumatic stress disorder, and I actually like to use an analogy that if you think about somebody who's been in a traumatic situation, say they're in a—you were talking about bullying, Cheryl was mentioning child abuse maybe in the home, that somebody who is in that situation becomes hyper vigilant. They're always concerned am I gonna be bullied again, is somebody going to hit me again. If you think about it like a car, think about a car that's constantly on idle and you're idling and idling and you're vigilant and you're ready to respond.

Ivette: Well, the adrenaline alone....

Larke:

It's going and going until it finally just breaks down. And so we see that people or kids, young people, adults, when they're constantly hyper vigilant like this, they need to figure out how to self soothe and sometimes they do it with medication, sometimes they do it with substances, sometimes depression sets in.

Ivette: Or highly active sexual behavior.

Larke: Exactly, those kinds of risk behaviors.

Ivette: Cheryl, why don't you continue.

Cheryl:

Well, I was just thinking about when we think about the neurobiology, someone that I've been very entranced by and impressed by is the work of Dr. Bruce Perry and he talks about that trauma occurs in developmental stages, and when it occurs in some of those more important developmental stages, so we think about intrauterine insult in the developing baby, so there can be trauma there. We think about 0 to 3, and also really thinking critically about what happens in adolescents where a lot of trauma really begins to occur. That impact on the brain at those particular points in time—and of course it's horrible for anyone at any point in time but some of those places in time is where the brain is really forming and developing and growing and the cognitive networks are—all those connections are being made and the trauma itself could interrupt those connections.

Ivette:

Sis, let me have you talk to the ACE study that Larke was mentioning that you brought to her. Can you expand on that and what were the findings of the ACE study and what does it stand for?

Sis:

It stands for Adverse Childhood Experiences study, and it was done in combination with the Centers for Disease Control in Atlanta and Kaiser Permanente out in California. And they had 17,000 people in the study. All of them had health insurance so these were not people who were desperately poor and without resources, and they were actually looking for new causes that they could address with prevention strategies for the chronic diseases that were killing our financial health system; heart disease, stroke, diabetes, cancer. The diseases that we had developed good quality treatments for and people were surviving, they were not dying from those diseases before. They had a cadre of people who were going through that who would start to get better and then they relapsed, and they began to look differently at how they would assess them and they began to ask them questions about their childhood and what they found was that children who had these ACE's, the Adverse Childhood Experiences; seeing your mother get hit, having a parent in prison, having an addicted parent or a parent with mental illness. People who had in their childhood suffered chronic emotional loss did not have healthy attachment to their parents because of what was going on with their parents, and decided that they needed to take a different tact, that maybe the best way to prevent heart disease and stroke when you're 60 is to have a healthier childhood.

Ivette:

Thank you, Sis. Art, I'm gonna go back to you. Sis mentioned something that is very singularly important and that is that there are differences between wealthy households and less wealthy or poor households when it comes to trauma and I saw the statistics on the briefing that we got for the show, and for the higher income household it was 16.9 per thousand versus 43.9 for the poorer households. Can you speak to that and how that really helps to—should help to develop policies that address these issues?

Art:

Yeah, because children from poorer households are gonna have more than twice likelihood that they're going to have adverse effects. I also think about another statistic that two-thirds of children experience violence by the age of 16. So when you look at that, and I know in my clinical practice, you're looking at children that for one, they didn't get good modeling and then the other is that their developmental phases have been disrupted and so they're not going through their developmental phases like what you would have in a family where you have all the resources available to you; good education, a nice bed to sleep in, three meals a day, all those things that you have in a normal—not even wealthy family but even middle income family. But in a poor family—I do a lot of work on reservations.

Ivette:

I was gonna say because those are generational issues, why don't you speak to that.

Art:

Yes. You have generational trauma and I have had clients that came from parents that went through boarding schools and you would think that the child had gone through the boarding school because they're experiencing the same symptomatology as the parents. There's that self-hatred like looking at yourself less than everybody else because here you were forced to—I've had clients tell me—this is one that's really bothered me for a long time. I had a client tell me that this he experienced. He was very young in boarding school. Him and his brother were taken from his parents and he would not stop speaking his native tongue and they were forcing him to speak English and he wouldn't do it. And they went and got needles from cactus and they kept pushing it between his nail and his finger, kept pushing it and pushing it. If you've ever gotten some kind of thorn or something, you know how much that hurts.

Ivette: Pain and discomfort.

Art:

Yeah, he was nine or ten years old but he still would not—he would still speak his native tongue and he's very proud of that, but it was also very traumatizing.

Ivette:

Larke, all of this that we've been talking about, as Sis alluded to that the ACE study found, deals with really causing an increase in chronic illness. Make that link for us.

Larke:

Sure. This discussion brings up so many different things. I'll try to get to that question as well as respond to some of what Art was saying.

Ivette:

Respond to Art first.

Larke:

I think what Art was saying is we often talk about it as intergenerational from one generation the passes to another. And we often have referred to that as historical trauma as well in some populations. So it really helps us think that trauma is not always just an individual experience but it's an experience by whole communities as well. So we think about community trauma and that kind of accentuates the context for the individuals when whole populations are disenfranchised or brutally their land is taken from them, that those things become incorporated into one's being and the perception of the world. So we're trying to really understand how do we address things on a community level as well because individual trauma occurs and we need to look at a broader population base in terms of our interventions as well. So I kind forgot you question.

Ivette:

I am going to come back to you on that second question. We'll be right back.

[Music]

Chris Shannon:

Door to Hope started 45 years ago. It was a small program that served basically alcoholic women who needed residential treatment services. It has grown from that one program to ten programs with a budget of over 7 million dollars.

Carolina Cortez:

The type of trauma we see here is moms who have been exposed to domestic violence who then the children are also been exposed to domestic violence; moms who use during their pregnancy, drugs and alcohol, so the children are also exposed in utero to that usage of drugs and alcohol with the effects that it has.

Edgar Castellanos:

They feel all alone, they feel shame, but for them they know that when they came to the MCSTART program we are now on their team, we're on their side, we're a resource for them.

Chris Shannon:

MCSTART is an early intervention program that works with children age 0-11 who have special issues or needs that put them at high risk for developmental problems.

Devona Campos:

I love MCSTART, I tell people about MCSTART. It's not just about drugs, drug exposure, it's about domestic violence, there's so much trauma; I didn't realize how much trauma my kid is going through.

Carolina Cortez:

The trauma starts in utero with substance abuse and also with domestic violence so the baby goes through the flight fight and freezes just like the mom does in utero with the domestic violence. With the drug and alcohol exposure the brain also is affected.

Edgar Castellanos:

Early intervention works, early treatment works, early assessment works, because we've seen children who are evaluated early on and now in their teenage years and are doing well.

Chris Shannon:

Outcomes for MCSTART predominantly are in the area of social and emotional growth and development.

Devona Campos:

MCSTART has given me the tools and the confidence to be a better parent and better mom to my son, more understanding of what happened and the trauma. I knew drugs were bad but domestic violence, I was like yeah, sure, he's protected. But no it goes beyond that.

Edgar:

The importance of the MCSTART program to me is the team approach and the fact that you have multiple people having eyes on the same situation.

Carolina:

It's more holistic because there's not one therapy that's going to work for everybody.

Chris:

We see upwards of 500 young children each year, our MCSTART program touches the lives of over 1000 adults and children each year.

Devona:

It's helped a lot, MCSTART has just been a godsend to us.

Chris:

Our primary goal is reunification and wholeness and wellbeing for the entire family. We see that in many many many of the cases that we work with, and that's very gratifying and very heartening.

Male VO: Your path to recovery isn't like mine

Female VO: You have your own struggles with mental health issues

Male VO: Your own challenges with substance use disorders

Female VO: You also have your own abilities and strengths

Male VO: But when you need a hand

Female VO: Reach out until you find one.

Female VO:

For information on mental and substance use disorders including prevention and treatment referral call 1-800-662-HELP. Brought to you by the US department of health and human services.

Ivette:

So Larke, let's go back a little bit to talk about the connection between trauma and chronic illness.

Larke:

Okay, so trauma often leads to high risk types of behavior. One of the most common risky behaviors is smoking, and smoking is we know very much tied to multiple chronic diseases. One of the earliest studies following the ACEs study that Sis mentioned, they looked at people who tried to do tobacco cessation, and those people who could not remain off of tobacco were people with more adverse childhood experiences. A very direct correlation. Obesity and tobacco use were directly correlated with some of the high risk adverse childhood experiences.

Ivette: Thank you. And the cost, Cheryl.

Cheryl:

I think the 2012 numbers, the cost of childhood abuse and neglect in this country was around \$214 billion, and per person it's somewhere around \$212,000 over a person's lifetime. So that's a tremendous cost and I think about just the human cost of suffering of untreated trauma and I was thinking about in the ACE study and the obesity piece and what that level of doing something over and over and over again to try and self-soothe and a person's experience of that, and then a person's experience of trying over and over again to stop smoking or to stop overeating or to stop drinking or drugging. It's that sense of failure that happens over and over again when a person can't succeed and the trauma is unaddressed.

Larke:

And those behaviors that Cheryl mentioned, chronic drug use, alcohol use, smoking; those are some of the highest risk behaviors for physical chronic diseases like diabetes, like cardiovascular disease. So you add all of those costs up and we see that trauma really accounts for a huge human cost as well as physical expenditures in our house system.

Ivette:

Absolutely. Sis, let's go to trauma-informed care. Let's talk about how we begin to address the service delivery of individuals who have experienced trauma.

Sis:

I think the first thing we have to do is to make sure we're looking for causes that happened earlier in the person's history. For soldiers coming back from the war who have suffered tremendous trauma in service, so many of them, a disproportion, a percentage of them came from dysfunctional and often alcoholic or drug addicted families and they joined the army in order to be safe, to be taken care of, to get educated. When I was living in Detroit, we did everything we could for the kids from the projects to help them pass, graduate and get into the army. It was their only ticket out of what was a disastrous life, and so they go into the service and they seem to be having everything under control and then the war

happens. And so we have so many people who are talking about PTSD as a result of the war and while that may be true, if we don't look to see what happened in childhood before they became soldiers, the treatment will be different and incomplete. So we need to look at the whole life spectrum. I think the same thing with the Native Americans. You know, we used to say that Native American people have a genetic predisposition to alcoholism and that's why it passes from generation to generation. Well maybe. But they also had this generational trauma from the boarding schools. They anesthetized that trauma, they grew up and became parents who were unhealthy and often dangerous parents and the cycle began. So we have whole tribal communities who have suffered from double trauma but we are only looking at one piece of it when we look at only the boarding school. And people get physically ill when they begin to remember what happened to them as children. So all that has to be looked at.

Ivette:

So Art, you own a clinic. Talk to us how you integrate trauma-informed care into the context of the service delivery system.

Art:

Well, one big part of the work that we do is to continue to—and that's one thing about trauma-informed care is for providers to gain the education and to continue to get education. There's updated—going back to the studies on the neuroscience, you know, gaining that information and passing it on to our clients, to our patients is really important. The other thing is that as a therapist, I don't want to re-traumatize our clients which is very important because back before we really knew that much about trauma or really looking into trauma, I believe there was a lot of treatment therapies or techniques that were used that were re-traumatizing. I mean I'm a Vietnam Veteran myself and went through some of those treatments back then and I can tell you there was a couple of times when I didn't want to go back because I felt like I was being re-traumatized and so I didn't and so I had to go seek something else. So to me that's really, really important for therapists, the providers, to continue to look into the different kinds of models and different kinds of therapies that are being used that are evidence based, you know, CBT or EMDR, stress management, whatever it is that we know are working. And one last thing.

Ivette:

So CBT is Cognitive Behavioral health Therapy and do you want to explain the rest of the—

Art:

Yes, and then your Eye Movement Desensitization treatment and then your stress management therapy and there's many others. But one last thing I want to say that I think is important in my state is that you have to think about the culture that you're working with. In Indian Country, as we say, in New Mexico,

you know, going back to traditional kinds of ways you have to experiment with it until you find just what works because just because you're in Indian Country, as we say, it can change from community to community. So you have to look at those aspects of it, too.

Ivette:

Very good point. And Larke, talk to us about SAMHSA's center and what is SAMHSA doing to really help integrate all of these issues into the whole new framework of health delivery.

Larke:

So SAMHSA just put out—actually we released in October of last year our concept paper for trauma and a trauma-informed approach, and by a trauma-informed care or a trauma-informed approach we came up with these four R's. I know we talked about the three E's, now we have the four R's and it really builds on what Art was saying. It really is kind of a public health approach to understanding trauma and making sure that your setting or your care delivery system takes into consideration what we mean by trauma. So we look at care delivery systems as realizing that trauma may play a role in the lives of the people that they're serving, that they need to recognize signs and symptoms of trauma, that they need to respond appropriately. So as Art was saying, responding with trauma-specific interventions like trauma-focused cognitive behavioral therapy, like eye movement desensitization response—that's a long one, I always mess that one up. And that they shouldn't be re-traumatizing the people who are coming into their clinic or into their system for care. And I have to say, again, years back before we were really understanding the role of trauma, we would be using techniques like seclusion and restraint. We used a lot of that with drug induced psychosis and not realizing how we are re-traumatizing people in the clinics that were supposed to be helping them. So we look at that idea of also trying not to re-traumatize. That re-traumatizing is not just for the clients or the people coming in for care but the staff who are often re-traumatized by some of the techniques that we thought at some point long ago were therapeutic. So we look at a trauma-informed approach as the culture of the setting that's providing the care. So you can provide great trauma-specific clinical interventions but if your clinic is not aware of how the receptionist could traumatize a person or somebody who's not in a therapeutic role, you can undo some of the clinical advances made.

Ivette:

So it's really looking at the entire service delivery system and training them to look for the signal and to also approach the client in a way that is sensitive to what that client may have experienced. And when we come back, I'm gonna go to Cheryl to see what the council is doing to address this issue. We'll be right back.

[Music]

Daryl Kade:

SAMHSA has supported the development and promotion of trauma-specific interventions. For example, SAMHSA has developed a National Registry of Evidence-Based Programs and Practices. In addition, SAMHSA has supported the expansion of trauma-informed care and promoted the consideration of trauma and its behavioral health effects across health and social service delivery systems. We have developed resources such as the National Center for Trauma-Informed Care, which provides technical assistance and promotes the implementation of trauma-informed approaches in programs, services, and systems and the SAMSHA GAINS Center, which provides technical assistance to support integrated systems, including trauma-informed care for individuals in contact with the justice system.

Male VO:

For more information on **National Recovery Month**, to find out how to get involved or to locate an event near you visit the **Recovery Month** website at recoverymonth.gov.

[Music]

Chris Shannon:

MCSTART is an early intervention program that works with children age 0-11 who have special issues or needs that put them at high risk for developmental problems.

Carolina Cotez:

Helping with families in their recovery is helping them live a successful life, to be an important part of the community in their own right and to have a voice.

Jennifer Hanson:

I'm in recovery but my son Giovanni is also in recovery from domestic violence and addiction. He used to act out very explosively, and by explosively I mean he was very aggressive physically and verbally. Now as a parent who's been through MCSTART, I now can step back and understand that I have to have patience and I have to be able to explain things to him in a way that a 5 year old will understand.

Devona Campos:

MCSTART has given me my child back, it has given me my confidence as a mom to help my son. I know how to tackle his problem whereas before I thought I was a bad mom. I didn't know what I was doing.

Chris:

What hope means for them is that their children will do better than they did.

Jennifer:

We went from homeless, I was drinking daily, and now we have a stable home, we spend time together, quality time together, it's just amazing, we have such a great support system through MCSTART.

Devona:

They don't judge me, they're here, and they're compassionate. They're very compassionate about our children and about us, and they're here to help us.

Jennifer:

It feels wonderful to be able to reconnect with my son. It's just a wonderful wonderful life. I could never trade it for how it was a year ago.

Carolina:

It's just good to see people who have potential to live to their fullest.

Devona:

There's hope, there's help out there, and there's a solution, there's always a solution. Don't live in the problem, live in the solution.

Ivette:

Cheryl, I wanted you to cover the whole issue of what the council is doing related to trauma and trauma-informed care. What are some of the resources that people can look to if they want to really identify how to deal with these issues?

Cheryl:

So just kind of going back a little bit, I am a person of lived experience of my own trauma and also with having significant mental health challenges and about 30 years ago I found recovery and in that recovery experience there were things that were still missing and I was given the opportunity to go through a program that really got to the root of what happened to me rather than the what was wrong with me and it changed the whole framework of how I looked and viewed myself and how I viewed the rest of the life that I wanted. And I began a career and was invited to come to the National Council as a Senior Advisor for Trauma-Informed Services and the first question my new boss asked me is I need you to tell me what a trauma-informed environment looks like, what does it smell like, feel like, sound like, what are the people like, everything. And so what we did is we set out to create a way to support organizations to begin to implement trauma-informed practices and principles, and we developed a tool, it's an organizational self assessment. It is not a checklist. It is a guide to having deeper conversations within that organization about what we do and how we do it and who we are in relationship to each other in every aspect of the organization. So when we were talking about the realizing the impact, the recognizing, the resisting re-traumatization and how we respond, we're looking at things like what are staff relationships like. When we were talking a few minutes ago, we were considering what happens when the receptionist treats you very, very poorly or

let's say that you've had a clinician that the session did not go very well and you have to go back and the receptionist is the one who actually ends up being the therapist in the situation. So really looking at all of the context of how people are within an organization and how we engage, considering that staff has also experienced trauma. We have a field that's traumatized by virtue of the work that they do. So how do we take care of staff, how do we engage with our community partners? I am a firm believer that trauma is a public health crisis or it's endemic in our public health and that we have a responsibility as providers to really be engaging with our communities and elevating this conversation. So the National Council provides learning communities for people, for organizations, we do individual technical assistance and then it's been amazing and it was with some funding from SAMHSA that we got our start in doing this work and we feel like we've really made great inroads.

Ivette:

Excellent, excellent. Art, I also know that you are yourself in recovery and I would like for you to really say when was that moment—and I want to say this because there are people in the audience who may have felt at one point or another, have felt the effects of trauma and can't even put their finger on it. So how do we help them to realize that they have these issues? How do we help the public realize that and how do we help them in a way of providing the resources for them to get better?

Art:

I think that the one thing that was really hard for me that I had to overcome was the stigma attached to both the alcoholism and the coming back from Vietnam. I can tell you that for years I wouldn't even let people know I was in the military. That's how much shame was attached to that war. And so at one point it hit me that I had become somebody that I never intended to become. I'm a former Marine. I went in the Marines when I was 18 years old and I did not go in the Marines to come back and be a failure or be a person that I wasn't proud of. I had some pride and one time and I realized I didn't have it anymore. So at that point I quit the drinking, got myself into treatment, got myself over to the VA, started working on my PTSD and then I also had this need to go help other vets and help other people to overcome the same thing. And today—

Ivette: Which is therapeutic in and of itself, is it not?

Art:

It's very therapeutic to give away—we have a saying that in order to keep it, you have to give it away. And today like if I'm at the gym, I have a Marine shirt on or something, an Iraq Vet will come over to me and we'll talk and one of the things that is still going on today that I feel bad for them is that same stigma, you know, because they'll tell me, if I go to the VA and admit my symptoms, they're gonna say I'm crazy and then I can't get a job and then my neighbors won't look at me the same way. So we're still overcoming that but I do believe those of us

providers that have that insight and have that nurturing part that we can help people overcome that.

Ivette:

You know, it's funny you should say that because as the child of an alcoholic and living in a family that had its share of traumatic episodes, the first out of my graduate degree from my rehab school, the first thing I did was to work in a program for Hispanics for physical and sexual abuse, emotional, physical and sexual abuse victims, and I mention that being sort of therapeutic because it really helps you to actually identify what you've gone through. I'm going to let you all give us some final thoughts because we've almost run out of time believe it or not. And Sis, any final thoughts for our audience in terms of how they can best deal with this issue and any other thoughts that you would like to share?

Sis:

Well, I've been thinking all through the panel about the "yes but's" that we get from the public; yes, but—you know, and then they'll mention some famous person who grew up in a violent alcoholic family, or yes, but look how they overcame, don't be a sissy. And I think that people do not understand the cost, the tremendous medical cost we discussed earlier, but we didn't really discuss the two hundred and some billion dollars that Cheryl mentioned about the cost of child abuse in this country. And that plays out in our juvenile justice system, it plays out in our schools, it plays out in our neighborhoods. And I think that we have lost something that we should try to get back in our country. We should try to get back something like the old Student Assistance Programs because those programs in schools provided educational support groups for kids very early on in their lives so that they would be sitting in groups learning something about what was going on in their lives and feeling free to break the silence that they have imposed on them by the diseases in their family.

Ivette: Absolutely. Thank you, Sis. Art, let's hear from you.

Art:

Yes, I think one of the things that I believe that we have to continue to do is to be more transparent in terms of recovery, talk about it more and more, talk about it in the schools. Kids respond to personal stories. I know that my children—and I have seven of them—that they tell me that they love talking to their friends about the work that I do and they'll tell their friends, well you know, you can talk to my dad. And they talk about recovery. They talk about whenever it comes up about trauma, they love to talk about what they've learned from my wife and I because my wife's a hypnotherapist. And then also about bullying. Bullying is something that I think we need to look at more and talk about it more in schools and I think the more we talk about recovery, the more it won't be something that people will be ashamed of. We need to take the shame out of—whether it's addiction or PTSD or any kind of mental illness.

Ivette:

Just to have everyone come forward and really try and seek help. Thank you. Cheryl.

Cheryl:

So I think kind of playing off what Art was saying and sharing a little bit of my experience, I think my final thoughts are is that posttraumatic growth is possible. That having a trauma history is not—there's not a dire prediction associated with that. People can heal, they can recover, we can move on with our lives. I'm an example of that.

Ivette:

Absolutely, and become more resilient. Larke, final thoughts in less than 30 seconds.

Larke:

Less than 30 seconds, okay. So I'm glad you mentioned resilience, and the recovery and resilience is really critical that people have hope and they know they can overcome some of these earlier life experiences or challenges. I do want to say that at SAMHSA we have a number of different types of resources. We do fund the National Child Traumatic Stress Network, which looks at a range of different traumatic events confronting children from young children through young adults, encourage people to go to those resources. We also fund the National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint. Again, lots of resources there. Finally, I also want to mention our GAINS Center and the Addiction Treatment Transfer Recovery Centers. They are all looking at the role of trauma and strategies for addressing and intervening; the GAINS Center particularly with criminal and juvenile justice, which we haven't talked a lot about.

Ivette:

I want to thank all of you and remind our audience that September is **National Recovery Month**. You need to look at recoverymonth.gov for information, kits and you can actually view this show on the web page. And we encourage you to do events in September and throughout the whole year because this is what it's all about. It's all about recovery and so that if you have a problem, seek help, and if you can help others sustain in their recovery, sustain it. We want to thank you for being here. It's been a great show.

[Music]

Male VO:

To download and watch this program or other programs in the *Road to Recovery* series, visit the website at recoverymonth.gov.

[Music]

Female VO:

Every September, **National Recovery Month** provides an opportunity for communities like yours to raise awareness of mental and substance use disorders, to highlight the effectiveness of prevention, treatment and recovery services, and show that people can and do recover. In order to help you plan events and activities in commemoration of this year's **Recovery Month** observance, the free online **Recovery Month** kit offers ideas, materials, and tools for planning, organizing, and realizing an event or outreach campaign that matches your goals and resources. To obtain an electronic copy of this year's **Recovery Month** kit and access other free publications and materials on prevention, recovery, and treatment services, visit the **Recovery Month** website at recoverymonth.gov, or call 1-800-662-HELP.

[Music]

END.