

**Understanding the Impact of Trauma in Developing Teen Pregnancy Prevention
Programs for Tribal Youth
January 29, 2013**

MS. GWENDOLYN PACKARD: Hello, everyone. I'd like to welcome you to this webinar on understanding the impact of trauma and developing teen pregnancy prevention programs for tribal youth. My name is Gwendolyn Packard. I'm a member of the Hunktalon Dakota tribe from South Dakota. I'm a survivor and advocate for women and children and a program specialist with the National Indigenous Women's Resource Center, the National Indian Resource Center dedicated to reclaiming the sovereignty of Indian nations by restoring safety for Indian women and children.

DR. CAROLE WARSHAW: Welcome, everyone. I'm Carole Warshaw, and I'm the Director of the National Center on Domestic Violence, Trauma and Mental Health. We're a special issue resource center that's supported by the U.S. Department of Health and Human Services Administration on Children, Youth and Families, Family Violence Prevention and Services Program.

And our Center's designed to improve program assistance capacity to serve domestic violence survivors and their children who experience a range of trauma, mental health and substance abuse and other needs and to develop culturally relevant responses to the range of issues survivors face in trying to free their lives of violence and heal from its traumatic effects. We work in the areas of policy, research, training, and capacity building and TA and also public awareness.

One of the things that's been really important to our work and to our partnership with Gwen and the National Indigenous Women's Resource Center is looking at both the individual and family aspects of abuse and violence across the lifespan as well as the

social, cultural, and political aspects that perpetuate violence and abuse and oppression and how to think about those issues together in ways that help us transform those conditions and their longstanding effects.

MS. GWENDOLYN PACKARD: So, as was mentioned earlier, all questions will be responded to either during the presentation or following it. And you will also have our contact information at the end of the webinar if something comes up that you heard today and you'd like to know more about or pursue further, please feel free to contact either Carole Warshaw or myself.

The objectives for today's webinar are to define trauma, including historical trauma; provide an overview of the biological responses to stress and trauma; to recognize how trauma (including trauma from teen dating violence) presents itself in Tribal communities; to understand the effects of trauma on individuals' ability to absorb prevention messaging; and to describe trauma-informed services and discuss how to create a trauma-informed environment.

DR. CAROLE WARSHAW: So, before we get started, one of the key elements of doing trauma-informed work that we'll be talking with you about today and that many of you I'm sure do already is the recognition of the pervasiveness and impact of trauma in all of our lives, which includes all of us as well as the youth that we serve in our programs.

And we know that talking about trauma and interpersonal violence can evoke painful memories and feelings. We listen to the people that we're working with and to each other and open our hearts.

One of the key components of trauma-informed practices for everyone to actively engage in self-reflection and self-care. And trauma informed organizations place a high value on self-care for staff and for the people that they serve beginning with you.

So part of what that means to organizations in training is to ensure that the structural supports are in place for that to happen. So part of what we want to ask you to do is to take a moment to think about what happens when painful feelings come up for you and what kinds of things you do to restore a sense of balance to yourself or to find your right to stand and protect yourself from that.

So what could you do during this webinar if that happened? Sometimes when we're engaged in our professional roles, we're more protected. And when we're just actually listening to people talk and reflect and things come in on different channels and may affect us differently. We know that working with people that have trauma history puts us at risk for experiencing vicarious trauma, which is often known as secondary trauma where when we actually open our hearts and minds to bear witness and walk with people; we're affected as well.

And we'll talk about how that actually works neurophysiologically in a little while. And we also can experience compassion fatigue, which makes it very hard to continue to feel empathy for other people because we end up shutting down to protect ourselves.

We also know that some of the materials that we may talk about can be triggering and that it's normal to have strong feeling when we're listening to stories of traumatic events.

And we need to find ways to protect ourselves to make sure that we don't do it at the expense of the people that we're working with and at the expense of ourselves and the people in our lives.

So just take a moment to think about that and also maybe think about how you do that in your own programs and training and outreach activities.

MS. GWENDOLYN PACKARD: Okay. So what do we mean by trauma? Individual trauma is the unique individual experience of an event or enduring condition, in which the individual experiences a threat to life or to his or her psychic or bodily integrity (or to a loved one); the individual's coping capacity and/or ability to integrate his or her emotional experience is overwhelmed.

We also want to define collective trauma which is the cultural and historical trauma which can impact individuals and communities across generations.

And we also want to define what we mean by historical trauma for purposes of this webinar. And that is that historical trauma is the cumulative emotional, psychological, and spiritual wounding, over the lifespan and across generations, emanating from massive group trauma experiences. And that the collective traumas of colonization affect nearly 100% of all Indigenous Peoples in the United States.

Within the historical context of trauma, we find the following conditions, such as contact or colonization. And here we like to use colonization as an explanation, not a rationalization. Genocide, the policies that were executed early on in our history with the

U.S. Government. And we've seen the effects of that in terms of the violence against women and children. And we know that women and children were the number one casualty of all the Indian wars that took place in this country.

Forced removal, locating large groups of Indian people to reservations and to lifestyles that were very different from the ones that they were familiar with. To go from a hunter and gatherer to becoming a farmer would be an example of that. Or going from being a hunter to suddenly becoming a fisherman and living along the rivers. So it's very different, a complete change in lifestyle. And the result of that and the impact of that on generations to come.

And then I know we're all familiar with the boarding school and the serious impact that that had on Indian people and the breakup of families and the removal of children from families and the impact that had on the ability of our parents and grandparents and great grandparents to parent.

We also have the sterilization that took place under the Indian Health Service for a period of about 20 years where 30,000 Indian women were sterilized without their knowledge or consent. And, of course, we have the changing Federal policies. And we find ourselves as Indian people trapped in a jurisdictional maze, especially how it impacts violence against women and the ability for us to have control of our communities and to help determine the welfare of our people.

And, of course, the reservation communities that we find ourselves in, oftentimes they were communities, as I mentioned earlier, that were totally different from our way of life.

And oftentimes those communities were very desolate and the ordeal we had of changing that lifestyle and living in these new environments.

And, of course, oppression and racism. And oftentimes when people talk about Indian people, they say, "Well, that was in the past. You all need to get over that." But we know that all of these are still very much with us today as Indian people. They're still very much a part of our reality.

But we'll be talking more of these. We kind of interspersed things throughout our presentation today to kind of go back and forth with trauma in indigenous communities.

DR. CAROLE WARSHAW: So part of ... when Gwen talked about the definition of trauma, part of how we've been talking over the last year and a half, is looking both at individual trauma and collective trauma and trying to think about how those intersect in all of our lives.

So I'm going to shift back and talk a little bit about the developmental effects of individual trauma. And then we'll come back to thinking about how this manifests in Indian country.

So first of all, I want to talk a little bit about trauma theory and how important that's been in shifting our understanding of mental health, mental illness, substance abuse, many of the things that we viewed in a very different way.

Over the past few decades, knowledge about trauma from empirically supported trauma theory led to a significant shift in the ways that mental health symptoms are understood.

It's helped to clarify the roles that abuse and violence play in the development of psychological distress.

So things that we used to think of as purely biological in origin, we now understand really are results from an interaction of our really life experiences and our biology. And we'll talk about that in a few minutes.

One of the things that's been so important is that trauma theory recognizes the role of external events in generating symptoms and asks whether and how symptoms may reflect coping mechanisms or survival strategies, adaptations to dangerous or frightening events or situations when other options aren't available.

So that's what we talked about as part of the definition. In other words, and many of you will have heard this and it's part of how SAMHSA's beginning to talk in its new definition of trauma and trauma informed services. It focuses on what happened to you rather than what's wrong with you. And focuses on resiliences and strength as well as psychological harm.

So it's really reframing things that have been seen as stigmatizing as making sense in the context of what happens to us in our lives. That kind of framework also fosters an awareness of the impact of trauma, including secondary trauma on providers, and really emphasizes the importance of organizational support and provider self-care.

And again, it's looking at we're part of the equation. We all can talk about how, at least with interpersonal abuse and violence, the harm occurs in a relationship and a healing

and restitution occurs through relationships as well. And that the quality of our interaction from relationships is critical.

So we also want to talk about how understanding the impact of trauma is critical to understanding what helps prevent it and what helps counteract its effects. So as I'm talking about the effects of trauma, I want you to think about when we talk about what it means to create trauma-informed services or trauma-focused interventions, that all of what we're talking about stems from understanding the effects of trauma and what we can do to counteract those effects, in our work and in our interactions and in our work in our communities.

It's also important to understand how our early environment, especially our early relationships with caregivers, affects our development and how those interactions are critical in influencing who and how we are throughout our lives.

So why is a developmental framework so important? Some of this stems from early work on child attachment and development and some of it's from the new neuroscience research that's really shown how you can actually see through some of these fancy brain scans how this actually works.

So what's important for us to know? Our brains grow in relationship to our experience. And the nature and quality of those experiences help to shape our development, particularly our relationship to early caregivers. So that neglect, stress, and trauma, particularly at the hands of people who should be helping us, affects our development. But strong early attachments as well as our subsequent caring relationships, and they

don't have to be from our families. They can be from our extended families and community and other resilient factors as well as their own internal capacities can counteract these effects.

Let me go back for a minute. As our brains develop, they require stimulation and they adapt to experience. There's a term called plasticity which is about how our brains continue to grow and reshape themselves in relationship to our experiences. And that there are critical and sensitive periods of brain development when change occurs most rapidly when we're very little and when the impact from experience is greater.

And during that time, there's a rapid expansion of our brains and the connections between them and that's why early life experiences are so critical. But we also know that throughout life, all of our experiences can affect us and affect our growth and development. Every time we learn something new, we're actually creating new pathways and new circuits in our brain.

So this slide is important because it reflects one neuron, one nerve cell in our brain. We actually have billions when we're born of these nerve cells. And during the first 5 years of life, they create trillions of connections. So just take a minute and think about how many connections we have and we're forming in our brain.

When you look at this one cell ... it's nice on a webinar because you can actually see the little dots which don't show up in a conference room. Each dot is a connection from this one nerve cell to other nerve cells. So just think about that. And it's really our experience that shapes how those can grow and develop.

So one way to think about that is, as I said, when we're born, we have about 200 billion brain cells or neurons. And the trillions of connections between them are what are necessary to make things work—particularly in the areas of higher brain functioning such as thinking and planning, reflecting, creativity, our empathy—that require us to connect up lots of memories and feelings and capacities and have them work together.

When we're born, those aren't every well formed. So part of how our connections develop is through a variety of types of stimulation, including, as I said before, interactions with caregivers, visual stimulation, hearing, sound, language, and starting to explore our world.

So like during a critical period, if your vision isn't stimulated, the part of your brain that processes visual information might not develop. Or if you don't hear language during that critical period, you may not develop the ability to form language and communicate.

So the ability of our brains to continually grow and change by building these new connections and letting others die off which is called pruning. So if we didn't have the capacity to let some of them go, we would just be flooded with sensory information and not be able to make choices and decisions and actually function in our life.

So it's critical to the process of fine tuning our capacity. And while different areas of our brains are responsible for different functions, for our motor coordination or recognizing emotions for storing memories, for laying down new memories, for critical thinking, all

the things we talked about, they all have to be coordinated and that's why those connections are so important.

So part of what we know is that babies who get lots of love and attention actually learn better. And it's partly because brain development depends on the way the brain is used and the extent to which it's used. So every experience we have excites certain pathways in our brain and leaves others inactive. And the ones that are consistently excited by experience are strengthened, while others that aren't stimulated kind of fade out.

So it's a combination of our genes, what we're born with, and nurture, our experience, that interact every step of brain development.

So basically, genes provide our basic wiring plan, but experience really helps to fine tune the architecture of the brain and determines which circuits will be kept and which won't. And what we now know is there's a whole field of neuroscience called ethogenetics that we're learning that it's the experience that creates chemical changes that actually turn genes on or off and determine it's not just that we're born with a gene that's going to do a certain thing. But our experience determines whether those genes are activated or not.

And each gene, actually what their team does is create a protein which creates a neural cap. So each one is a tiny step in a process of making us who we are.

The other critical thing to understand and the importance of the physiological effects and the importance of those early relationships that also not only wire our brains, but part of what they wire our brains for is how we feel about ourselves, how we feel about other

people, and how we feel about the world. It's a model for our future relationships and for our ability to trust other people.

So our earliest interactions with our caregivers, including love and care and nurturing and consistently getting our needs met, begins in utero. When we cry, when we're hungry, when we come to expect that people respond to us, we learn that we're loved and that we're worthy of care. And those relationships with our early caregivers become a model for other relationships.

So the other critical piece about that early development and attachment—it's a really important source for our developing our own capacity for resilience and our ability to manage stress and those protective factors that we develop early on really help us throughout our lives.

It also helps us develop a template. You think about the wiring of our brains for developing our capacity to understand and manage feelings and develop some of those integrated capacities that we talked about, to be able to think and feel and connect to other people, understand what they're feeling; and that those are active throughout life. When our caregiver isn't able to provide that, we have many other opportunities for developing this capacity.

Part of how we learn that is through what we call mirror neurons. Actually, our capacity for empathy in a human is hard wired. And as children, we learn by watching and imitating and matching, sort of resonate with the people. So we're in distress and we cry as a baby and we don't have those systems developed in ourselves, when a caregiver

responds to us, we match up with what they're doing and then we develop them internally. So then eventually, we can do that on our own.

So what happens when that doesn't work well? One of the ways we think about this is normal stress, traumatic stress, and complex developmental trauma when trauma occurs early on in our childhood and affects all of those capacities as they're developing.

Another way to think about this comes from the work of Daniel Shonkoff at Harvard at the Center for the Developing Child. And he talks about this as positive stress which refers to the types of stress that are part of everyday life like meeting new people or dealing with frustration. When it's experienced within the safety of a warm, nurturing relationship and adults help us manage our feelings, it keeps the level of stress response manageable and helps us to develop our own capacity to manage stress and a sense of mastery and self-control. So it's an important part of our healthy development.

He also talks about tolerable stress, which are events that could trigger physiological responses that can potentially disrupt our brain architecture, like being hospitalized or the death of a family pet, that are relieved by supporting relationships. And what makes them tolerable rather than harmful is the presence of a trusted and supportive adult or adults whose actions can protect us by reducing our sense of being overwhelmed. And it helps us literally turn down our stress response system so that it doesn't overwhelm our capacity which is part of the definition of trauma.

And then he talks about toxic stress which is when there's a strong, prolonged activation that the body stress response system and the absence of the buffering protection of adult support. And that's where we see the longstanding effects of abuse by trauma.

So let's look at this more closely. I don't know if you've heard of this Yerkes-Dodson Curve. It's about, again, tolerable stress and intolerable stress. And I think we know a certain amount of anxiety and stress may help us mobilize and perform; and that when it's too much, it gets in the way and distracts us and keeps us from functioning.

So normal stress, as I said, is necessary for growth and survival. And I'm going to skip to the next slide, but what you'll have is the kind of verbal description of what I'm going to show you graphically.

What happens is we've developed our stress response system to protect us from danger and threats. It's hard wired in. Animals have it as well. And I think you've heard of the fright, flight, or freeze response. So what happens is we perceive the threat, and it's relayed to our senses—your eyes, ears, nose, sense of touch—to what we call a sensory relay station in our brain which is called the thalamus. And that sends out messages for really rapid response to our alarm system that allows us to mobilize a whole cascade of chemicals that allows us to either fight back or to flee.

And that there are slower response systems that then allow us to kind of take a step back and say, okay. This is squiggly screen thing that I'm having this stress response to; is it a garden hose or is it a snake? And then there's an actual slower response that guides you to the higher cortical functions, the top of our brain. It allows us to think and

evaluate and matches up to decide: do we really need to be upset now? Or is this really not a threat?

So let's look at this as a diagram that helps us see this more clearly. It's a very simplified version of what happens. And the reason I'm showing it to you is because this piece of our response or trauma has robust research behind it and helps us make sense of some of the responses that we may have and that the youth that we're serving may have that we find distressing and that they find distressing. And when we understand it, it really helps make sense of that and helps us respond more effectively.

So a threat comes into our thalamus or our sensory-related stations, and we have this rapid response from the amygdala that is part of the brain that's involved with fear processing and that sends out the cascades that are adrenaline responses or cortisol response that mobilize our ability to respond to that.

This is the next level slower response, the hippocampus which is the pattern matching recognition and memory. So that we can say, "Okay, this is something we've seen before and we don't have to be afraid. Or this is something that we have to fear." And then the slower response to our cortex, the thinking part of our brain.

When the stress goes away, we come back to baseline and all of those systems that have been—we call it arousal—have been activated, come back, and restore a sense of balance, harmony, and calm.

So what does stress do? It shifts us away from a sense of emotional balance and predictability and calls on our system to restore that. So that's what we just saw with the normal stress response.

Traumatic stress, prolonged exposure to traumatic experience without anything that helps us restore that sense of calm, shifts us away from that sense of safety and predictability and disrupts our system's ability to restore it. So when you think about someone who has post-traumatic stress disorder and they're in a continual state of hyperarousal and hypervigilance when they're being flooded with memories, and they hear a loud noise and feel like they're being shot at, or that they're reliving the traumatic experience. That's what we're talking about when our system can't get back to normal. It responds as if we're continually in danger.

So let's look at how that works. So the threat comes in. And the threat can be abuse, violence, coercive control, or ongoing oppression and discrimination. We have that rapid response to a threat. And when it doesn't go away, that response gets strengthened. And the other parts of our brain aren't working as well. We may not develop those pathways as effectively, or they may just be offline if the stress and trauma happen later in life.

So we're reacting as if we're continually under siege. What happens then is: think about a kid who always is going to anticipate threats. And so they go to school and they're anticipating danger. So they respond with aggression and hostility. And then they get in trouble. And then they end up in a completely different developmental trajectory.

Another thing that can happen, the freeze response, disassociation, which is when we kind of vacate the premises, psychically when we can't do it physically, we all dissociate in different ways. When we're driving down a highway and we notice we've lost track of time.

So that's a normal response that we have. But again, when that's turned on permanently, it interferes with our ability to function. We really dissociate when something is a reminder of something, but isn't really it. Or we may disassociate in ways that allow us not to be present. It's a protective mechanism, but it also keeps us from paying attention to our surroundings and noticing things that might be dangerous to us.

So what happens is instead of those fear pathways being activated, actually the pathways that calm down the fear pathways are overactivated and dampen that response to the extent that we're not able to engage and be present.

So if someone is disassociating as a kid, they may go to school and not be able to be present and not be able to absorb information or take it in. And that may also put them down a different pathway. Again, thinking about kids who are in your programs who are either overreactive to potential threats or disassociating and not able to engage and process information, that's going to affect their ability to use the services that you're providing.

This slide from Nicky Miller just gives us a sense that there's a whole continuum of ways that can be effected from the hyperarousal to the numbing, from the disengaging or to be intensely focused on potential threats, from having a heightened sense of awareness or

just being dulled and shutdown. Or from having feelings that are overwhelming to not even being able to know what we're feeling or feel anything.

So there's a whole range, and we can move back and forth on that continuum. So again, think about the youth that you're seeing in your programs and how they may be affected and how that affects their ability to interact.

So since this section talks about how what we do makes it different. So we're back to someone experiencing traumatic stress. And when we intervene and provide safety or we change the conditions that are producing the trauma in the first place, when we remove the threat and that fear pathway may diminish somewhat, but it doesn't go away. Because it's wired in and it takes a long time to change those neuropathways.

When we intervene with medication, it actually literally damps down that fear response. And one of the things that it's important to know is that the natural pathways we have the receptors in our brain that help inhibit and calm down. The fear response. The receptors are called GABA receptors. They're the same receptors that drugs like alcohol and diazepam like Valium, organics, or Ativan bind to. So when our natural pathways for inhibiting that fear response don't work, we may select drugs to use that help do that externally. And when we intervene through therapy or social support or advocacy or the skills that we help provide in our program, it not only helps people to learn how to calm down those responses, it also helps them to build new pathways and strengthen the ones that help us be able to think clear and plan and process information.

So there's a lot of factors that are involved and there are a lot of things that we can do that make a difference. So thinking about how this translates into our experience. So trauma can affect our capacity to trust other people. So psychologically, we talked about early attachment relationships or betrayal later on, when trust has been betrayed, it makes it hard to reach out and trust other people.

So when we're ... it makes it hard for us to turn to other people for help. Or when we are starting to depend on someone that we're working with in a program, that may suddenly become dangerous because the people we trusted and the paths betrayed us. And then we have to do something to disrupt that. And so when we talk about complex trauma or the trauma that comes from early experiences of abuse and neglect, one of the things that gets disregulated besides our ability to manage and emotions in our internal affective states is our ability to feel good about ourselves and our ability to engage in relationships that maybe helpful, that may be able to comfort us and soothe us.

We also—it affects our ability to experience ourselves as deserving and worthwhile. And one of the things that really interferes was developing and feeling bad about ourselves because of the ways we were treated and what we took in from those experiences. So again, when we talk later about how this may lead to higher risk for teen pregnancy, think about the kinds of things we can do to help counteract those experiences critical for our program.

It can also affect our ability to solve problems, to exercise judgment, and to process information. And we know that some of those things are challenging for adolescents in

the first place. So when you add the experience of trauma, that makes that even more complicated.

So again, tailoring our intervention to take in the experience of trauma and to do some work with kids in ways that help them develop some of those capacities that then allow them to make use of what we have to offer.

So in sum, our brains develop in relationship to our early experiences, neglect, stress, and trauma, particularly at the hands of our caregivers, really affect our development. But at the same time, there are many, many opportunities to counteract these effects, both early on and through the kinds of programs that you're providing. I'm going to stop now and switch over to Gwen and think about how this translates for tribal communities.

MS. GWENDOLYN PACKARD: Thank you, Carole. So how trauma presents itself in tribal communities: earlier on, we talked about the context of trauma. And now we'll shift to the historical trauma response which is we know that in tribal communities based on the data that's available, that we have some of the highest rates of child abuse and neglect. And we also know that what we had mentioned earlier about removal of children from families and the boarding schools. And so we see a lot of that in present day when we look at those high rates of child abuse and neglect.

We also continue to deal with racism in tribal communities, especially in the border towns, and the impact that racism has on children growing up and witnessing it with their parents and the treatment they receive when they go to border towns to buy groceries, even within the school system.

Another historical trauma response is bloodism where half-breeds or full-bloods or you're part this or part that. I think in the United States, we're one of the few people that are always having to deal with blood quantum issues and who's Indian and who's not Indian? I can't think of another culture in our country that really deals with that to the extent that Indian people have to deal with that.

And then our reservation communities: we have high rates of bullying and lateral violence and we also experience the high rates of suicide among our young people in a lot of our tribal communities. We also have high rates of crime and antisocial behavior.

And some of this was taken from a report that was done for SAMHSA on trauma in tribal communities. And we have all our citations and our resources at the end of this presentation for you to go back and review that. And so some of this is the language that was taken from this SAMHSA—I think it was like a focus group or a committee that had gotten together to look at that.

We also see the high mental health impact in our community. We have high rates of depression, high rates of addiction, substance abuse. We have mental health impact. Children from very, very, very early ages, high rates of depression. And very few resources to deal with a lot of this. And so those situations go unchecked and unnoticed for many, many years in our children.

We have physical illness: some of the highest rates of physical illness in our Indian people today. We have a very young population, and we also have a population of the

highest rate of ... the life expectancy for Indian men is like 55 years old. We have some of the highest rates of illness and mortality rates. We have high rates of sexual abuse, chronic depression and suicide, disconnection from the education system.

Report cards that have been done on schools in Indian country show that there's a high dropout rate, that very few finish high school. That's not to say that years later, they do come back and get their education and even advanced degrees. But early on, we see very high dropout rates. The internalized oppression that we experience in tribal communities sometimes.

I know that growing up, we used to always hear the story about the crawfish and how we won't let anybody get out of the pot. How we always hold each other down. That's a story I'd heard early on. And we experience a lot of those things in tribal communities. And then, of course, there's the high rate of family violence and child abuse, domestic violence, the lateral violence, the violence among siblings, elder abuse, all the different types of abuse that we see in that context.

The next slide was one that was created by Mario Brach who works with Native American Professional Parents Association here in Albuquerque. And it's on intergenerational trauma over the lifespan and across generations.

And when you look at it, I kind of think of it more as a spiral because it just kind of continues to spiral from experience to adaptive coping responses to how that's normalized in the family and used in relationships, how that behavior's carried on throughout our different life stages. And how the next generation comes in, and it starts

all over again with exposure and observed violence and experience. And we see that continuing to spiral across generations and within the context of family and family members.

One of the things that I've been really impressed with is the adverse childhood experiences study that was done years ago. And recently, we were doing a training, and a bunch of us took those 10 questions to find out what our ACE score was. And for those of you who aren't familiar with the ACE study: I think almost everyone's familiar with it.

But some of them are, you know, did a parent or other adult in the household swear at you, insult you, put you down, or act in a way that made you afraid or that you might be physically hurt? Did a parent or other adult in the household, often or very often, push, grab, slap, or throw something at you or ever hit you so hard that you had marks or were injured? Did an adult or person at least 5 years older than you ever touch or fondle you or have you touch their body in a sexual way? There's a series of 10 questions.

And so in the non-Indian ACE study, if you responded to four or more of those questions, it puts you into this whole big risk category of becoming an alcoholic or a drug addict when you get older. And there are a number of risks that came with that, with just four or more questions.

But when we did it in a group of Indian providers and caregivers and healers in our community, most of us were an 8, 9, or a 10 on that score. So when you think about just four, the amount of risk that that puts you into. And then when you look at the group that

we were working with, we're a very highly traumatized group of people. And yet, we're doing this work in our communities.

There was a study that was done on seven Native American tribes, and again using those 10 categories of adverse childhood experiences. But they included boarding school, foster care, and adoption as cultural variables. And in those, they showed 86-percent experience in one or more categories of exposure and 33 percent reporting four or more, which I thought was pretty low for tribal communities, based on a lot of the experience that I've had in working in tribal communities.

And so when I asked some of the authors of the study about that, they said they agreed. They felt that one of the reasons for that was that they used non-Indian key informants to ask the questions. And they felt that if they had used Indian people to ask the questions of Indian people, they would have gotten a different data set for that. But out of that study, of course, the rates of alcohol dependence were significant, and the lifetime prevalence of alcohol dependency was high among all those tribes except for one.

On the next slide, they just kind of recap that. And then the combined sexual and physical abuse increased alcohol dependence for men. And the combined sexual abuse and boarding school attendance were significant for women. And women with the ACE score of four or more had a seven times increase in alcohol dependence.

This is another chart that was developed by Dee Bigfoot out of the University of Oklahoma, Childhood Trauma Center. And again, it's just another way of illustrating the

impact of most if not all of those things that are on the ACE study such as incarceration, substance abuse, suicide, domestic violence, child abuse and neglect.

But on this one, she puts it in the background of poverty because another thing that the ACE study did not take into consideration is poverty. And, of course, we know that in tribal communities, we experience high rates of poverty and high rates of unemployment. And also we deal with historical events and historical trauma across our tribal communities.

Go to the next slide. So I started to mention earlier in the presentation about Indian people. There's 4.5 million Indian people in the United States, and we make up about 1.5 percent of the total U.S. population. But of that number, 1.3 million people are under the age of 18. So we have a very, very young population. And we have less than 336,000 over the age of 65.

I work at a national resource center. And we often hear that in a lot of tribal communities, they don't have elders. Or they have elders that are in their 40s or late 40s, early 50s. Because that's about as old as you'll get to be in that tribal community. And so we're really losing our elderly population at a higher rate than other cultures or rates. Although Indian women live to be about 70 years ... I think we live to be 62 years; that is our average life expectancy, a little bit more than men. That's still a very young age when you compare that to the life expectancy across races in the national population. And then, of course, over 65 percent of our people live in off-reservation communities.

One of the things that we wanted to talk about is the roots of violence against Indian women and girls. And as I mentioned earlier, I'm a survivor and an advocate for women and children. What we know is that woman is the heartbeat of our communities. That woman is the foundation of our families. That women are life bearers and life givers. And that women or woman is the first environment. We all came into this world through a woman. And yet, it seems bizarre that the highest rates of victimization and violence are against women.

Native women are two and a half times higher than any other race in the U.S. victims of sexual assault and that one in three women will be raped in their lifetime. Native women are victims of domestic violence at a rate of 64 percent. And Native women are stalked far greater than any other race in the United States.

Native women are murdered 10 times higher than the national average and Native women live their lives in the dangerous intersection of gender and race. In a recent study that just came out from the Centers for Disease Control on interpersonal sexual violence by sexual orientation, the majority of women who reported sexual violence, regardless of their sexual orientation, reported that they were victimized by male perpetrators and that nearly half of all female bisexual victims or nearly 48.2 percent and more than one-fourth of women in general or 28.2 percent experience their first rape between the ages of 11 and 17. And I thought that was just, you know, their first rape, that it would even be described that way because then it seems like maybe there's more to follow. The language is just shocking.

So data on intimate partner violence and person-to-person crimes clearly shows that most violence perpetrated towards women is perpetrated by men. And as I'd mentioned previously, it was women and children who were the number one casualty of all the Indian wars in the United States.

I just wanted to mention the gender-based violence in the context of this presentation and also to talk just briefly about historical trauma and contemporary pain. And here, I'd just like to ask you to think about understanding the impact of historical trauma on tribal youth. And I know that we kind of have a new term that's emerging from all of that that is an historical trauma by proxy. And that's what a lot of programs that we've heard from experienced in working with youth: is that the youth are feeling the impact of the historical trauma and acting out on it without really understanding why, without really understanding what's happening to them and why they're doing the things that they do.

And in working with youth, a lot of people that we've heard from say that it's been really helpful and healing in their communities when they go back and look at historical trauma and they talk about it. And they go back generation by generation against the timeline of discovery in the United States and look at what the impact that each of these historical things have had on different cultural people.

And I know it varies from tribe to tribe and from regions in the United States to regions in the United States. Since we all had contacts differently and with whether it was the British, the French, or the Spanish, but things were different for all of us.

But there are similarities and there are strong lines that run through all of that. When young people are able to understand that historical context, it helps them understand themselves a whole lot better.

So throughout our presentation, we developed some questions that we'd like you to think about as you do the work in your community with your youth. So the question that we have regarding historical trauma and youth is what have you seen in your community? And what has been the impact of historical trauma on your youth? And with that, we'll move into trauma and teen pregnancy with Carole.

DR. CAROLE WARSHAW: Yeah, but if you people want to write in their responses to those questions. So I'm trying to bring us back to thinking about trauma and teen pregnancy. We know that youth who are exposed to violence are more likely to become teen parents. And if you're a teen parent, it's likely that you're more likely to have experienced abuse and violence. And when we think about sexual violence, we also think about historical trauma and boarding school experiences. So think about how all of these intersect and how our responses need to be both individual and collective.

So in some studies, as many as two-thirds of young women who become pregnant as adolescents were sexually and/or physically abused at some point, as children or in their current relationships or both. And a substantial number of adolescent mothers [are] in violent, abusive, or coercive relationships or are in abusive relationships either before, during, or just after pregnancy.

We also know that younger women are at greater risk for coercive, non-consensual sex. One study found that involuntary sexual activity and the experience of 74 percent of sexually active girls younger than 14 and 60 percent for girls younger than 15. At that age, girls are at very high risk for coercive sexual experiences.

So how does this relate to teen pregnancy prevention? I'm sure you all know from your experience that this is the case and that you can see, I mean, these slides are meant to just show the research that corroborates that. Why might that be? What have you seen in your experience? Feel free to write in.

One of the risky coping strategies. So part of showing those slides earlier about how the kind of dis-regulation that happens within our brain and our physiology from experiencing ongoing traumatic stress, that we don't develop our internal capacity to regulate, we have to use external means to do that.

So self-medication with drugs and alcohol is one way to do that or risky behaviors that are ways to try to distract ourselves from those feelings or to match up externally what we're feeling internally. Engaging in early sexual activity is a way to bind feelings or to make connections. Some of the ways that really trauma can play out is increasing our risk for teen pregnancy.

We also know that sometimes trauma in the home can lead kids to being what we call premature parentification where you're forced to behave, act as an adult, particularly if you're the oldest child or the oldest girl in the family and you're taking care of the other

kids; that may lead you to earlier sexual activity as well. Or a need to get away from your family.

At the same time, some teen parents who've had a history of childhood trauma experience parenthood and the feelings of being able to protect the child as a new source of hope for themselves and for their children, for the future. So getting pregnant, as I'm sure you're well aware doing the work you do, can serve a lot of different functions.

There's one other study I wanted to talk about which was by Mylant and Mann. It was all pregnant and parenting American Indian teen mothers who were primarily of the Northern Plains that were served by an adolescent pregnancy program in the area in the Indian health hospital and a tribal women's health program were asked to participate. And it turned out there were only 43 of the 186 young women who participated. Their average age was about 17 and a half.

And you can see that 61 percent reported intimate partner violence. And for almost 40 percent of those, it was during pregnancy. And over 22 percent reported current coerced sexual activity or forced sex in those relationships.

They also found that almost half, about 42 percent, had a chemical dependency problem, and there were higher rates of depression. A lot of the trauma symptoms of hyperarousal and feeling bad about themselves and disassociation. So a lot of the things that are the traumatic effects of abuse are also things that put kids at greater risk.

Another interesting study that parallels the ACE study, and I just wanted to mention quickly: one of the things about the ACE study, they used to think that one of the things they found was [that] there was a dose-response relationship between every category of every childhood experience you had increased your risk for developing not only problems like substance abuse and depression and a range of mental health problems, but also all the leading health problems like diabetes and high blood pressure and heart disease and lung disease.

And they used to think it was liver disease because of smoking and alcohol and drug use. But I think what we've come to learn is that it's really the effect of early life stress on our neurophysiology. All of those chemicals that pour out to respond to stress end up affecting not only our brain architecture but also all of the organs in our bodies. So again, understanding those effects and developing interventions to help counteract them is critical.

MS. GWENDOLYN PACKARD: So we want to just talk briefly about teen dating violence, and we began with the definition of that which is the ongoing pattern of coercive control in the context of a dating relationship.

And I know that a lot of us that are older, it's a whole new world out there in working with young people. And we hear from a lot of communities that they don't even use the word "teen dating violence." That's really old school. And then if you want to use the language that the young people use, then they think you're trying to act young and stuff. So I don't know what the answer to that is. But I just wanted to ask you to think about the language that you use in the programs in working with the youth.

The dating violence is the ongoing pattern of coercive control in the context of a dating relationship. And it may include physical, sexual, or psychological abuse or electronic aggression or economic coercion. It may include sexual or reproductive coercion, mental health coercion, or substance abuse coercion. And it may include all of those.

So one of the questions that we have for you again is based on your experience— and we got a pretty good response from that last set of questions. Based on your experience, are there other dimensions you would add to this definition in the work that you're doing in your communities? And again, please feel free to type in your responses. Or if this is something you want to think about as you go forward in your work. Do you want to add to that, Carole?

DR. CAROLE WARSHAW: No, I'm looking at the time and I want to make sure we get to some of the interventions. So I'm thinking about maybe we should move a little more quickly through some of the next couple of slides and get to what we mean by trauma informed and culturally responsive.

So what I'm going to do now is kind of meta talk through what's on these slides so we can get to the next part. This one is about how all of these issues intersect. So not only does trauma increase the risk for using substances as a way to self-medicate, but also in a teen dating violence relationship, survivors are coerced into using and prevented from abstaining.

So there are both parts, the impact of trauma and the ongoing coercive control. I'm sure you've heard about birth control sabotage and reproductive coercion where they say you can't use condoms and you're prevented from using birth control. So that's a critical direct piece of how kids increase the risk for teen pregnancy. But the other, the mental health and substance abuse coercion, makes people feel like they're crazy, that they're using, that no one will believe them. And it reduces their ability to reach out for help and for protection. So all of those are connected to each other.

That when you're looking at adolescents, thinking about the ways we talked about trauma, there are some particular ways it can be manifest in adolescence. So kids can be particularly embarrassed and ashamed about what happened, but they may also feel really uncomfortable with their feelings and feel like they're going crazy or there's something wrong with them or they don't have a way ... if they haven't been able to talk to anyone about this, to have any perspective on their feelings.

And the kinds of intrusive nightmares and insomnia and fear and anger and irritability, all those things are part of the trauma response. But think about how they may manifest amongst kids that you're seeing in your programs.

And again, when adolescents are trying to manage feelings, in addition to some of the self-medication and the risky behaviors they may engage in are things that you're again seeing and working with the kids in your program, including reckless driving and wishing or planning or trying to seek revenge. And I think that's something we see a lot too. And it comes up when we see it with adolescent boys who aren't able to protect their mothers who are being abused by their fathers or by another male partner.

The difficulties in concentrating and learning and all the changes the kids are going through and their self-image is going to be effected by trauma. So again, as we're developing our programming, a lot of the things that are part of the tribal PREP program that are helping kids towards a healthy adulthood are all areas that can be affected by comments. So again, factoring that in is critical. And I'm assuming that's stuff that you're already doing. Gwen.

MS. GWENDOLYN PACKARD: So in a strength-based approach, resilience is a critical ingredient defined as the capacity for successful adaptation despite challenging or threatening circumstances. And I know it was always described to me as our ability to kind of blow in the wind. And that when they knock us down, we get right back up again and get right back at it.

But one of the questions that again we'd like to ask of you are what are some examples of resilience that you've seen in working with young people that haven't necessarily been defined or used in the general population? What are some examples of resilience among Native youth that you've seen in your communities?

DR. CAROLE WARSHAW: You know, we always want to come back to this: that we're all survivors and that focusing on strength and resilience is really critical and all of us continuing to do our work and in the work that we do in our programs.

This is a summary slide. I'm not going to go through the details of it. I just wanted to add one thing that was from another study that it was kind of an anti-ACE study and they

showed that—it was about teen pregnancy— that family strength actually mitigates the effects of the ACE, the Adverse Childhood Experiences. And those who are feeling, people in your family felt close to each other, that the family was a source of support, that people looked out for each other. There was someone to take care of you and protect you. There was someone in your family who helped you feel important or special, that you felt loved, and there was someone to attend to your health needs.

So again, those are things that in study looked at family, but we can also look at community or we can also look at the supports we're providing in our programs and how that makes a difference.

MS. GWENDOLYN PACKARD: And I think too, just to back up on the resilience one, when a report came out on one of the major networks about the use of Pine Ridge or the Oglala reservation, it was so negative that the youth on that reservation put together their own video that they put on YouTube that said we are much more than that. And I thought was an incredible example of youth resilience.

So we are at Trauma and Adults. So, I know we're kind of speeding through this towards the end, but another set of questions that we have that we'd like you to think about is based on everything that you've heard, how does this fit with what you're seeing? And what else are you seeing in the young people you are working with? And how does trauma affect their response to your program? Do you see trauma having an impact on their ability to participate or benefit from the programs that are being offered?

DR. CAROLE WARSHAW: So moving along, but we do want your response. How does understanding this help? One of the things that's been really critical is that understanding trauma helps make sense of the sometimes confusing responses, feelings, and behaviors we encounter while we're doing our work. And it makes it really critical how important it is to create relationships that feel safe and are based in empathy.

And when we know how challenging it is to make the connection when trust has been betrayed. We can talk about that with kids and not say, "Oh, you should trust me because I'm a good person and trying to help you." But we know that that's hard and that's something that we'll have to build together.

And then it also means, well, we understand our own responses to trauma and when we understand our reactions to ... we understand why people are behaving the way they do and see that the behaviors that we may find challenging as survival strategies and coping strategies that allows us to take it less personally, to be less reactive, and to step back and say this makes sense. It may be getting in your way. Let's think about other ways, other things that can be helpful.

And making sense of it, even using those diagrams of talking about how trauma affects the brain; it's such a relief to some people. It's like this makes sense. It's not because I'm crazy. It's not because I'm bad. It's because this is how people are affected by trauma. And these are the things that it takes to change that. It takes time and it takes time to build new pathways. And it takes a lot of resources and support and skills, and we can do that together.

So all of that understanding and information can be empowering. So when we don't have a trauma framework, we can inadvertently re-traumatize people by interacting in ways that evoke a feeling of what it was like to be abused or by not being aware of trauma, potential trauma triggers. Without a DV framework, we may not be attending to safety, and it can be endangering. And we don't attend to culture and human rights. We're not responding to all the issues that make people feel unsafe.

So what do we mean by trauma-informed services? A couple of things that are really important. One is that when I first started doing this, you said, Gwen, what do you mean by trauma-informed? And we talked about what it meant. Oh, that's what we're doing anyway. We just didn't call it that.

So we assumed that many of you or most of you are doing this already. But I'm going to lay it out. And this came from the work of Maxine Harris and Roger Fallot who are working actually in Community Connections which is the mental health center. It was really a liberatory movement for people who had been really incarcerated in the mental health system. And nobody understood that many of the reasons they were there had to do with trauma and that their experiences in that system in fact not only were re-victimizing, and so re-creating the experience of trauma was very coercive and controlling.

When we recognize that, we're looking at the effects on all of us and recognizing that we're an important part of the equation too.

So think about one of the critical elements of trauma-informed work is not recreating those experiences. So, the do no harm level. And the next one is not doing things that are potential re-traumatizing. And that means sometimes it may mean being directive and controlling in ways that feel like people who didn't have choice or control no longer have it.

So it's counteracting the experience of abuse. I'll give you an example from the DV world. Maxine Harris actually came up with that. And we asked healthcare providers to ask routinely about ongoing abuse and violence. But you have to do that in a safe private setting where the abuser isn't listening in. You might say to someone, you go into a room and say, "What you say here will stay between the two of us in this room." And that may be a relief to someone worried that their abusive partner is standing outside.

For someone whose uncle said that to them when they were five, that may be terrifying and going into a closed room with someone who's an adult, who they don't trust, maybe very frightened. Thinking about all those kinds of things. We know that anything can be a trauma trigger: a loud noise, someone inadvertently brushing into you, touching someone in a way that we think is comforting may be very frightening, a sound, a smell.

So it's beginning to think about trauma triggers, anticipate them, and help kids prepare for them. So that they can start to learn how to regulate and to do some of the things that kind of turn down that stress response, some of the kinds of relaxation, meditative kinds of activities, physical activities.

But when we talked about early development and attachment and needing someone externally to help you develop those capacities internally, it's part of what we do with adolescents if they didn't develop that early on, but in ways that are particular engaging to them.

So that when we respond in ways or the kinds of things you would do with teens anyway, that kind of respect, honest, genuine way of interacting, that's part of being trauma informed. Part of what Maxine Harris talks about is the kind of Jekyll/Hyde or the experiences people have with someone where one minute it's really friendly and engaging and loving and then they turn on them and you never know. You can't predict when someone's going to turn on you.

So if one day we have a lot more time and can be very present and engaged and other times we're really stressed and have 20 things to do, and we're writing grants and reports. and we're much more kind of brusque, that may feel like that Jekyll/Hyde response and something to think about.

So again, it's thinking about all the ways that people are affected and all the things we can do to counteract that. So when we talk about providing information and tools, making sense of people's experiences is empowering. Having people work on skill-building. What you're doing is, I think, a critical part of your program. You're also talking about emotional skill-building and affect regulation skill-building and interpersonal skill-building to help to counteract the effects of trauma.

And again, what ways do we have in our own programs, in our own lives, to nourish our own ability to stay emotionally present to process things that make us kind of protect ourselves and shut down or become hypervigilant and not as emotionally present?

When you think about those diagrams when we're in that response mode, that success response mode, we don't have access to our more thoughtful, reflective, and empathetic capacities. So what do we need to do to bring us back to help us then be present for the people who we're working with. And what do our organizations do to help us get there?

So when we create environments and other aspects of being trauma informed and thinking about what's the physical and sensory environment like? And is it welcoming? Would someone feel like they want to be there? And if it's too chaotic and overstimulating, are there places to be quiet if that's an issue? What's the interpersonal relational environment like? And does everyone feel welcome and cared for? And how flexible are our programs so that we can account for people's ability to process information or need to disengage or step away like we did when we talked about finding our long distance?

MS. GWENDOLYN PACKARD: So the really big message we want to say here is that a welcoming environment says you belong here. I think we're going to move even quicker here and ask the question: Do you ever wonder? I think that's the next slide, Carol.

DR. CAROLE WARSHAW: This is just a way of posing ... this comes from my colleague Carrie Pease. When an adolescent's behavior gets in the way of the work and of responding to what we're offering and using services. What do we think about them? Are we thinking

about it? How do we understand that? Do we think they're just not interested? Do we understand it in the context of trauma? And I think it's just thinking about the effects of trauma getting in the way helps us reframe our stance and our understanding and allows us to respond in ways that are more helpful.

MS. GWENDOLYN PACKARD: First change how we are and that will change what we do. And do you want to finish that, Carole? Then I'll go into the next piece?

DR. CAROLE WARSHAW: So thinking about it's the quality of our interactions. That's how we talk about nurturing and attachment and development, that those qualities is what kind of helps to counteract and undo the experience that's being treated, being objectified and dehumanized, and treated with disrespect and not having any control over what you do. So again, it's thinking about that, and centering ourselves allows us to respond in different ways.

MS. GWENDOLYN PACKARD: And that was one of the things— I had run a domestic violence program for a number of years. And in working with the women, we did a lot of staff training because it was all about what we were bringing to that first time we meet with a woman. What are we bringing with us? And really have to do a lot of self-work to do that work. And how we want to be treated, how we would treat the women and children and how we would want to be treated. And we really had to look inside for all of that.

I just want to talk briefly about cultural values and practices. When Carole and I first started talking about trauma-informed care and practices and approaches, we found that we were really doing a lot of parallel work. We found that in a lot of tribal programs, that

they were already very trauma informed in their approach, that they welcomed women, that they offered sweetgrass or sage. And food was always a very big part of that. Have you had something to eat? Would you like a sandwich? We'd always have a pot of coffee on. There was always something to offer, to create that warm, caring environment.

And then we also promoted cultural awareness and education, as many practices as we could that were unique to various tribes, and it depends on where you live. But we always made sure that if women wanted a sweat lodge, that we could find that and make that available for them. Because we found that the greatest work that we could do was through promoting cultural activities, that women related to that and it brought women together. It kind of sealed relationships.

And I think one of the big ones we had was making relatives. And for a lot of women—and I'm just talking about this in the context of domestic violence. By that time a lot of women had been isolated and alienated from their families and friends. And so it was really important for them to come into an environment where they had relatives, where they had sisters or grandmas or aunties, that they could create that relationship with everyone that was on the staff and then amongst the women themselves that oftentimes were not born into these supportive, loving environments. And so we create them for ourselves. And we found that to be very successful in working with the women and children.

We're emotional beings. We're spiritual beings. We're mental beings. We're sexual beings. We're so many things. I think one of the big things is that we're spiritual beings

on a human journey, not human beings on a spiritual journey. And I know that was kind of life altering for me when I first came to that realization because it makes you look at the world in a whole different way.

We're victims of violence, often a Westernized approach does not acknowledge the spiritual wound of the whole being. And I think that's one thing that really to me has always been significant about Indian programs and working in tribal communities is it often takes on a very holistic approach. The whole being is being treated rather than not just the domestic violence or the violent instance that brought this person in or the truancy at school, but rather looking at that whole picture, that whole individual in terms of the healing process and what brings people and communities together.

Ways of knowing. Native life is centered on the four seasons, the four directions, in the natural world. And traditional spirituality is not so much a religion as it is part of our everyday existence, beginning with prayer and ending with prayer, and our prayers throughout the day, the things that connect us.

Native spirituality and beliefs are sacred. To use them in any other way than the way they were intended would be sacrilegious. And, of course, we know those things do happen in our communities. And also learning to live in the traditional way is not easy. It's a very hard road that, you know, it's a very steep climb for a lot of us to take and a new way to begin.

Just kind of backing up a little bit, some of the ceremonial and sacred ways that we found very useful, highly beneficial in working with women and children are the full moon

ceremonies. And these vary again from tribe to tribe: cedar baths, wet lodges, fasting, wiping of tears ceremony, healing women's camp, healing camps for men. These camps have really been incredible and made a difference for women and men. It's a time when they can just all come together and talk about the things, and there are spiritual leaders there to help guide them. Picking medicines, using medicines, drumming, singing, use of feathers, sacred fires; all of these things that we've incorporated into a lot of our healing ceremonies that we did.

We just want to end with this because we want to make sure we do have some time for questions and answers. And I really love this indigenous proverb because again it speaks to the role of women and that women are sacred. And that [is]: if the emotional, mental, physical wellbeing of a woman is intact, so too is that of her family, community, and society.

And so I want to thank everyone for participating in this webinar. And sorry we got a little rushed towards the end. I know Carole wants to have an opportunity for some parting words as well. And then we'll ask John to unmute everyone, and we'll have a question and answer period. And I think we have a little while that we can do that. So Carole, some parting words?

DR. CAROLE WARSHAW: Yes, I just want to say that the work that Gwen and I've been doing over the last year and a half has been really wonderful for me and thinking about ... and also with Kathy Sanchez from Women United, the first webinar that we did together, thinking about a much more holistic approach, thinking about trauma as a collective trauma, not just individual trauma and a much more holistic approach to healing and

healing not only ourselves, but our communities and our society has been really critical. I think it's a really important way to work on trauma forward.

Because part of what we're talking about is not just healing the effects of trauma, but trying to do something about the things that created it in the first place.

MS. GWENDOLYN PACKARD: So John, if you will unmute people and describe the process.

VOICE: All guests have been unmuted.

OLIVIA: This is Olivia at RTI. I'm here with John, and we just unmuted all the lines. So the first thing we'd like would be for everyone to manually put their phone back on mute so that we don't hear a lot of background noise, if that's possible. And then up in the top menu on the right, you can see there's an icon with someone holding their hand out.

If you have a comment or a question, feel free to click on that so that Carole or Gwen can see that you would like to talk. And then when they call on you, you can unmute your line so that you can have a conversation. Gwen, Carole, it's about 4:29 and we're supposed to end at 4:30. But if folks are willing to stay on, we've got the technology as long as you need it.

So again, please click on the hand raised icon up in the top of the menu bar if there are comments or questions that you would like to share. It doesn't look like we've got any verbal questions. If folks have any questions or comments they'd like to type into the Q&A box or into the chat box, that would be fine. And while it looks like we've got at least

one grantee who's typing right now, while we're waiting for that to come through, there was a question at the very beginning about whether the slides will be available.

We did send the slides out to tribal PREP grantees, to folks who are on the contact list that RTI has from FYSB. So if there are subawardees on the phone or folks who did not receive those slides, you may want to get in touch with the primary contact at your grantee organization. And I'm sure that FYSB can also make sure that the OAH grantees get a copy of the slides as well.

Also, for tribal PREP grantees, we will post these slides on our community practice website so that you can access them there.

MS. GWENDOLYN PACKARD: And again, our contact information is available at the end of the PowerPoint presentation. So if anyone would like to get ahold of us, that's how you can do it.

DR. CAROLE WARSHAW: There's also slides with reference materials and links. And we both have a lot of other additional materials on our website.

OLIVIA: It does look like we have a question, Carole and Gwen. There's a question about the recording of this webinar. For tribal PREP grantees, we will post the recording as well as the slides on the community practice website. I would say that they should be up probably by Friday. And we will send the recording also to FYSB for posting on the FYSB website which is public and available to everyone, not just to tribal PREP

grantees. I don't know what the turnaround time is for that posting, but we'll be sending it this week to FYSB and then they'll post it as quickly as they can.

It doesn't look like we have any other questions or comments. Wait. There is a comment. Carole and Gwen, would you like to address this comment about food for thought?

DR. CAROLE WARSHAW: Gwen, what do you think? I think it's a great comment. I agree.

MS. GWENDOLYN PACKARD: I do, too. From Farah Dikro, yes, thank you. I think that it really should be a requirement as well because it really creates an understanding whether it's personal or organizationally or however you want to use it. To me, I think it's incredible information.

DR. CAROLE WARSHAW: It's really about understanding it and how we can transform all of that. It's both together.

MS. FARAH DIKRO: Hi, this is Farah Dikro.

MS. GWENDOLYN PACKARD: Oh, hi.

DR. CAROLE WARSHAW: Hi.

MS. FARAH DIKRO: Just the reasoning behind that is that with the high teen pregnancy rates, one of our communities is actually thinking of building a day care center into their school system. And I just think ... one of our other coordinators and I were discussing this briefly

... but I just feel that if we're going to have ... allow or enable our teens to say, okay. Come back to school. We're helping you with your education and whatnot. We really need to set the precedent that we don't want their younger sister thinking, oh, well, my sister got pregnant and the school helped them. So she's graduating. But have more of an infrastructure into what's really going on.

And since there obviously [are] going to be teen parents and they're going to be parents themselves, just to get the baseline of all of this knowledge, the sooner the better for them and pass that on and hopefully be a good leader or role model for their younger siblings or cousins or whatnot. And it might even allow their parents to get more involved.

MS. GWENDOLYN PACKARD: Thank you, Farah.

DR. CAROLE WARSHAW: All the things that help parenting and ensure that bond and kind of developmental guidance in supporting good parents of teens who are getting pregnant as well as teens as parents, all of that has the potential to be informative.

OLIVIA: It doesn't look like we have any other questions or comments at this time. Oh, wait. There's one right here. There's another question about has there been any research? Or has anyone else seen trauma-exposed Native youth getting involved in gangs at early ages?

MS. GWENDOLYN PACKARD: One of the men that I've been working with is Dan Foster who's a psychologist at Rosebud who works with youth. And he's done a lot of work in that

area. For a number of years, he worked in corrections. And then he returned to his reservation in South Dakota and he does a lot of work with the youth. So he speaks a lot about that. I don't know if he's written or if there's written research about it. But he talks about the gangs which we know are on probably every reservation. I don't think anyone's immune from that. And he talks about from his years in corrections that everything that he saw in Sing Sing, he sees at Rosebud. That the violence is just incredible in that community. And we hear it from other communities as well.

Another person is Yahi Swazo who works with the Pueblo of Hamath here in New Mexico. And he does a lot of talking about the gangs and that youth are being indoctrinated at a very, very early age, almost at the age of 5 or 6. A lot of these kids already know a lot about that stuff. So he talks about early intervention programs that can work with youth regarding gangs and gang violence.

OLIVIA: We've got another question. When engaging with our youth, we have them view the future. But they tell us as facilitators, you're selling dreams. Because they go home and see the effects of historical trauma. How do we turn that to a positive?

DR. CAROLE WARSHAW: Thinking about you were talking about the training you did in New York State and the kinds of transformations people were able to create in their communities. Gwen?

OLIVIA: Gwen, are you still on? Carole, it sounds like Gwen may not have a connection right now by phone, even though she's still logged into the link.

MS. GWENDOLYN PACKARD: I'm sorry, there was a helicopter flying overhead. I had to put it on mute.

DR. CAROLE WARSHAW: Oh, you muted. Okay.

MS. GWENDOLYN PACKARD: I was like, oh, no. This can't be happening. That was the second time that happened during a presentation. I know if I put you on mute, you wouldn't be able to hear anything. That's really a tough question that she posed. And it's a very, very real question about selling dreams. Because a lot of times, the homes that these kids are going to ... I grew up on the reservation and I'm a dreamer. It's kind of hard to describe.

But I know that some of the work that's going on with youth in a lot of tribal communities has really been helpful, and it's all around media and creating, you know, the technology's there for them to create their own videos and to do their own music. The ones that I've seen that have been really successful are those that really rely on technology to really help youth realize their dreams and their potential, the stuff that they're able to post on YouTube and the number of friends that they're able to have, you know, the number of hits they're able to get on websites that they've created and stuff like that. And that's been some of the most incredible work that I've seen happen out there, whether they're showcasing art work or whether it's poetry, whatever their medium is, they are able to realize that dream and see that possibility through the available technology. And that's just based on experience of things that I've seen.

DR. CAROLE WARSHAW: The other thing I was thinking, Gwen, was this whole concept of toxic stress and tolerable stress. If someone's going into a situation that is really traumatic and they can't avoid it. I mean, maybe there are things that could help change their situation. Or going into a system. Or working with the legal system where you're just you against things that are not going to be in your favor necessarily. How do you provide the kind of support and perspective and care and nurturing that helps someone manage those situations, even though those situations themselves aren't good.

So it's not like just you're in it, but you have allies and you have a sense of yourself outside of it and some possibilities for a whole other developmental path that's outside of what you experience in those settings. And that's kind of what you were talking about, Gwen. But it's also how do we help people negotiate situations that aren't good in a way that allows them to be in a different place with themselves and connected to other people who are different?

And I think a lot of programs are doing work with mentors. So you know that there are other people, that there's another nurturing, caring adult or peers who make that difference in your life. It's one of the protective factors that really makes a difference in general and for pregnant and parenting teens.

OLIVIA: It doesn't look like we have any other questions or comments here.

DR. CAROLE WARSHAW: Well, if you think of things afterwards that you want to ask Gwen or ask me or email us or setup a conversation, we're happy to do that.

MS. GWENDOLYN PACKARD: Also, if there are training areas or something you would like to flesh out more like the last one we had from Martina, contact our resource centers because we'd be happy to work with you on some of that and bring in other providers as well.

OLIVIA: So, are we signing off?

MS. GWENDOLYN PACKARD: I don't know. Have we signed off? Hello?

OLIVIA: All right. Thank you, everyone for joining our webinar today. And if you do have follow-up comments or questions, feel free to reach out to Gwen or Carole or your project officer. Thank you so much. And we're signing off now.

MS. GWENDOLYN PACKARD: Thank you. Do we call back on the other number?

OLIVIA: Yes, you call back on the other number.

(END OF TRANSCRIPT)