Mental Healthcare

You would like to collaborate with the client on using mental healthcare as a Stress Buster! Before getting started,

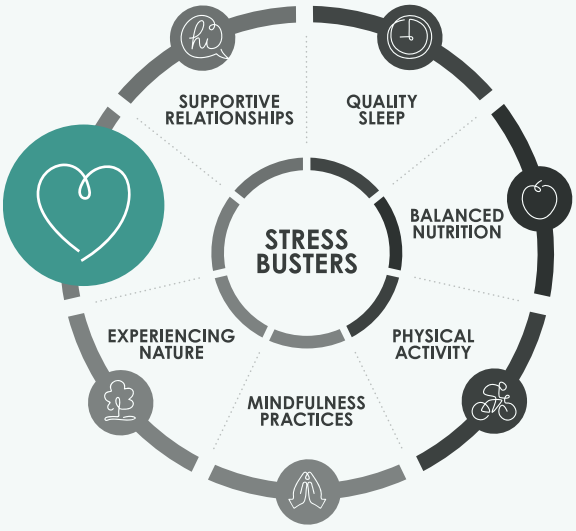
⚠ Is your client in the midst of a mental health crisis or do they have concerns about their immediate safety?

- If you have a client who needs to talk to a mental health professional immediately (and none are available at your organization), the client can call/text/chat the 988 Suicide & Crisis Lifeline, or you can do it with them.
- For more crisis and safety support resources, including knowing the warning signs of a mental health crisis, go to: www.acesaware.org/managestress/safety/.

If they are not in crisis, ask yourself:

- ✓ Has the client been connected to services and programs to address immediate needs or stressors?
- ✓ Has the client been presented with a brief overview of all seven Stress Busters?
- ✓ Did the client express interest in learning more about mental health care?

Use the information and trauma-informed steps presented here to ask and **listen** for what clients want to prioritize, **partner** with clients to find things they can do every day to help calm the stress response for long-term healing, and **connect** clients to programs and services if they want more support. **For more, see this chapter's *What you can do: Listen, Partner, Connect* and *A trauma-informed approach for mental healthcare* sections.**



Former U.S. Surgeon General Vivek H. Murthy, MD, MBA described mental health as "encompass(ing) our emotional, psychological, and social well-being, and is an essential component of overall health... It is the springboard of thinking and communication skills, learning, emotional growth, resilience and self-esteem."[1] "Behavioral health" is a broader term that includes mental health as well as emotional and social well-being, and behaviors and actions that affect wellness.[2]

Concerningly, mental health and behavioral health conditions, such as anxiety, depression, substance use, and suicide continue to grow.[2–5] Research shows that the trauma and stressors experienced during the COVID-19 pandemic further exacerbated mental and behavioral health concerns for children, youth, and adults.[1] The former U.S. Surgeon General called mental health, particularly for our youth, an urgent public health issue that requires multi-sector approaches to address it.[1]

CBOs can play an important role in providing mental and behavioral health care. All CBOs can offer non-clinical strategies that support mental health and well-being and some may specialize in providing treatment for mental illness. A CBO's role can start with understanding how trauma and stress affect our mental and behavioral health. Staff can:

- support clients in using everyday, trauma-informed strategies including the Stress Busters to promote positive mental health and well-being.
- work with clients to identify when they may need additional support, such as mental health hotlines and referrals to trauma-responsive mental health, behavioral health, and substance use specialists.

How do trauma and toxic stress impact our mental health and behavioral health? Having four or more Adverse Childhood Experiences (ACEs) has been associated with increased risk for mental and behavioral health issues, including memory problems, depression, anxiety, and panic attacks.[6–15] Knowing this reinforces the importance of working with every client – and especially clients with mental and behavioral health issues – in a trauma-informed way.

Increased risk of mental and behavioral health conditions for people with 4+ ACEs

Health condition	Odds ratio/increased risk
Unexplained physical symptoms like pain and headaches	2.0-2.7
Anxiety	3.7
Post-traumatic stress disorder (PTSD)	4.5
Depression	4.7
Memory problems	4.9
Attention-deficit/hyperactivity disorder (ADHD)	5.0
Using illegal drugs (any kind)	5.2
Smoking cigarettes or e-cigarettes	6.1
Panic attacks and severe anxiety	6.8
Drinking alcohol heavily	6.9
Missing a lot of school in high school	7.2
Being a victim of violence (like domestic abuse or sexual assault)	7.5
Being violent towards others	8.1
Using drugs that are injected, like crack cocaine or heroin	10.2
Using cannabis	11.0
Having learning or behavioral problems as a child	32.6
Suicide attempts	37.5

How to read the table: A client with four or more ACEs is 4.9 times more likely to have memory problems than a client who has fewer than four ACEs. Note that the odds ratio only indicates increased risk – it does not mean that a person will develop this health condition.

Source: ACEs Aware

Substance use and trauma

Research shows that people who have experienced ACEs are more likely to have behavioral and mental health issues – and also that many people who are using substances have high rates of trauma in their past.[9,16–18] In fact, it is estimated that the rate of treatment for substance use disorders is five times higher for people with post-traumatic stress disorder (PTSD) than for the general population.[19,20] Also, ACEs are associated with increased risk for substance use disorders and eating disorders.[21–27]

Research is beginning to show the ways in which toxic stress is an underlying mechanism for substance use disorder. Studies reveal that substance use can be a coping behavior, used to self-medicate or self-soothe.[26] In addition, ACEs and trauma are associated with disrupting the reward-processing pathways in the brain, possibly making people with ACEs or trauma more susceptible to addiction.[22–24,27]

Studies show that adding trauma-focused therapy to treatment for substance use disorders can improve outcomes.[28–30]

To learn more about the link between trauma, eating disorders, and mental health, see the balanced nutrition Stress Buster chapter.

Neurodiversity and risk for ACEs, toxic stress, and mental health issues

Neurodivergent individuals (people who are autistic or have other neurological or developmental challenges like attention-deficit/hyperactivity disorder (ADHD), dyslexia, or other learning disabilities[31]), are at increased risk for ACEs and mental health challenges, especially for those managing stressors such as financial instability.[32]

Being a neurodivergent person in a world designed for neurotypical people can be a constant source of stress. Systems and structures are not set up to support different needs.[33,34] Sensory sensitivity to bright lights or loud sounds leads to daily activation of the stress response.[35,36]

Neurodivergent individuals experience high rates of discrimination[37] and may be bullied or experience social isolation. Race may play a role too: people of color who identify as neurodivergent may be more vulnerable to stress and feelings of disempowerment.[38]

In interviews, young autistic people and their parents reported that their co-occurring mental health issues – such as severe anxiety and depression – were the biggest obstacles to their futures, not their autism.[39] Also, research shows that individuals with autism are seven to nine times more likely to engage in suicidal behaviors than non-autistic people.[40,41]

Society and culture do not always appreciate people's different strengths, beauty, and brilliance.[33,42] When working with neurodivergent clients, it can be helpful to consider that we all have challenges and need support for different things. We can work to learn and understand – from a place of curiosity and humility – the various ways that clients experience the world.

For more information about neurodiversity, visit www.acesaware.org/managestress/cbotoolkit.

The science: How mental healthcare is a Stress Buster

Stress response	› Mental and behavioral health therapies can treat toxic stress by regulating brain, immune, hormone, and genetic functioning.[43] • Child-Parent Psychotherapy works with both the child and their caregivers to heal from trauma. It has been shown to reduce depression and PTSD, lower stress, and make both parents/caregivers and kids feel more capable, especially if the child has experienced a lot of ACEs. It has even been shown to slow down the genetic aging process associated with toxic stress.[44] • Post-traumatic stress disorder (PTSD) treatment for adults can lessen physical reactions (e.g., a racing heartbeat) that can happen in response to stress or triggers.[45]
Brain health	› There is a growing body of research into effective trauma therapies, including top-down approaches that help people be more aware of and open to changing unhelpful thoughts, behaviors, and emotions,[46] and bottom-up approaches that help associate body sensations with specific emotions and help them heal[43] (see the *What You Can Do: Listen, Partner, Connect* section below for a list of therapies).
Heart health	› The American Heart Association advocates for mental health therapies including cognitive behavioral therapy (CBT) and the other Stress Busters as they can decrease risk for heart disease and improve outcomes.[47]
Immune health	› Psychotherapy (e.g., cognitive behavioral therapy (CBT)), psychological interventions (e.g., mindfulness), and psycho education, have been shown to reduce inflammation and strengthen the immune system.[48,49]

Challenges

Many different factors – including those beyond our individual control – can affect our mental health. Recognizing that there are structural/systems-level factors that can cause challenges to accessing mental healthcare can reduce feelings of blame and shame. And, asking about these challenges can allow for more targeted individual-level solutions for clients.

Following are some examples of challenges; this is not an exhaustive list. In addition, racism, discrimination, and inequities at all levels can contribute to and exacerbate any of these challenges.

Structural/systems-level challenges

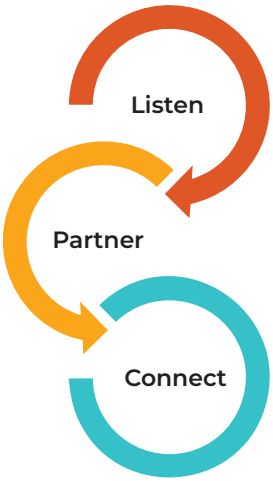
Policy-level factors	Policy-level factors such as health care system and reimbursement structures: › Availability of mental health and behavioral health providers, especially those who have training in addressing trauma › Limited coverage of mental health care by insurance plans › Availability of long-term care due to closure of psychiatric hospitals starting in the 1960s and the deinstitutionalization of patients without changes to the mental health care system to meet the needs of chronically mentally ill people[50–53] › Availability of integrated behavioral health services (e.g., embedded mental health care, such as in community or primary care practice settings)
Societal or cultural factors	Stigma (e.g., negative stereotypes, prejudice, and discrimination) against mental health challenges and mental health care; distrust in mental health care providers due to historical trauma (e.g., harm inflicted on Black people through psychiatry and psychology)[54,55]

Interpersonal/individual-level challenges

Cultural factors	Culture can influence how individuals engage in mental health care; e.g., individuals who identify as Hispanic may manifest mental health challenges (such as anxiety and depression) in somatic sensations,[56] and so may seek help for "aches and pain," not recognizing the concept of "stress" or the emotional origins of one's symptoms.
Interpersonal factors	Availability of, and therefore access to, culturally and linguistically compatible provider(s)
Socioeconomic factors	Availability of mental health providers who accept insurance; disproportionate number of providers available to individuals only at high costs
Psychological, cognitive, and relational factors	Availability of, and therefore access to, mental health care specialists to support neurodivergent individuals; delayed awareness or diagnosis of manifestations of trauma or neurodivergent presentations Experiencing or having fear of discrimination or social stigmatization resulting in personal shame about mental illness[57] Assumptions that no therapy will help due to experiences with an incompatible therapist and/or a type of therapy that the person feels does not help them (versus continuing to try to find another therapist or type of therapy (e.g., cognitive behavioral therapy,[58] somatic therapy[59]) that works for them).

With these challenges in mind, it is important to always take a trauma-informed approach to mental health and behavioral health, to honor individual experiences, and prevent re-traumatization. This toolkit provides individual and organizational-level approaches to mitigate challenges (for organizational-level ideas, **see the chapter, *Promoting Stress Busters at the organizational level)***.

What you can do: Listen, Partner, Connect



The way you talk about Stress Busters with clients matters. ACEs Aware community and clinical partners shared that in their experience, it is more effective to engage clients with Stress Busters through conversation and partnership versus telling a client how to "fix it."

Using the **Listen, Partner, Connect Framework** is a way to remember how to structure a client conversation about Stress Busters and how to interact with clients using trauma-informed and strength-based approaches.

Listen

Ask open-ended questions and use compassionate active listening to understand clients' needs and desires around the mental healthcare Stress Buster from their perspective. Not everyone who has experienced ACEs or trauma will need mental or behavioral health therapy.

Example questions:[60,61]

- How are you feeling today? Is there anything you want to talk about?"
- Thank you for sharing, that is a lot to have to go through. How are you holding up?
- What helps you during stressful times? What has helped in the past? Who helps you? Who has helped you in the past?
- What helps you feel more relaxed or calm?
- When you're stressed, are there things you do that you want to change?
- How would you like things to be different?
- If you woke up tomorrow and could magically have no stress in your life, what would that look like?
- How can I help support your mental health?
- What do you see as your next steps?

For more information about how to do active listening, see the toolkit chapter *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients*.

Reminder: Create safety and trust

- Validate and normalize clients feeling strong emotions, such as by saying: "If you are feeling anxious, sad, or isolated, you're not alone. These feelings are common."
- Establish emotional safety by reassuring clients that they will not be blamed for their experiences and coping responses, such as substance use.
- Consider how best to share information about mental health with clients, such as through trusted, culturally competent messengers like promotoras.

For more examples of how to apply SAMHSA's six key principles, see *A trauma-informed approach for mental healthcare* section of this chapter.

Partner

Base the conversation and next steps on what a client needs or wants. There is no need to lecture or "fix" someone. This is a partnership and a collaboration. If a client gets stuck or is not sure what to do, check in with them by asking, "How do you see me being able to help?"

- **Use the ACEs Aware handout as a guide in the conversation if helpful:**
  - "Nurturing Our Mental and Emotional Health Can Help Prevent and Manage Stress" (from www.ACEsAware.org/managestress).
  - Explain the concept of "flipping our lid" using the visual model to describe how stress can shut off our thinking brain and turn on our emotional, impulsive, instinctual brain; we can use techniques like mindfulness to help us stay in our thinking brains (for more information on the visual model, see the *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients* chapter of the toolkit).
  - You can also use the Window of Tolerance concept (see the *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients* chapter of the toolkit) to explain how it is normal to sometimes get thrown into fight, flight, or freeze mode and why some of us get upset more easily or in more extreme ways than others. We can all widen our window of tolerance by practicing Stress Busters and getting mental health support when needed.
- **Use strengths-based and collaborative approaches with the client,** such as motivational interviewing, to discuss strategies for supporting their mental and behavioral health and for them to choose what works best for them, such as the following ideas from community partners and clinicians:
  - Get immediate help: If a client is in crisis or has immediate safety issues, help them contact a crisis hotline (see a list at www.acesaware.org/managestress/safety/).
  - Discuss behavioral health challenges: If the client has talked to you about behavioral health challenges such as substance use or an eating disorder, ask them if they would like to discuss ways to address them. If they are interested, connect them with a trauma-informed substance use therapist or mental health CBO.
  - Lessen the load: Reduce stressors by getting help with housing, food security, or relationship struggles.

- Practice mindfulness or grounding techniques: For more information on relaxation techniques, see the *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients* chapter of the toolkit.
- Spend time with loved ones or friends: Talk to a trusted relative, friend, religious or spiritual leader, or community member. For more information, see the supportive relationships Stress Buster chapter.
- Practice gratitude: When you notice good things that happen, recognize them, for example, by writing them down in a journal or by saying "thank you" to someone else; at the end of each day, think of three things you're grateful for.
- Volunteer: Join a club, group, or community organization and do activities that provide meaning and purpose.
- Shut the screens: Find time for fun that's not connected to your phone– listen to music, spend time with animals, read a good book.
- Move your body: Boost endorphins and manage stress in the moment. For more information, see the physical activity Stress Buster chapter.

For more information about how to use motivational interviewing techniques, see the toolkit chapter *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients*.

> ### Reminder: Focus on strengths and collaboration
>
> - ✓ Acknowledge and value clients' resilience and strengths that have enabled them to survive adversity.
> - ✓ Help clients understand what they are feeling and what might be driving behavioral and mental health issues by supporting them in learning to name their emotions.
> - ✓ Talk about mental health in ways that reflect your client's preferences and comfort level. You might discuss how we all can fluctuate between a wide range of mental health states during our lifetime, between wellness and illness ("mental health continuum").
>
> **For more examples of how to apply SAMHSA's six key principles,** see *A trauma-informed approach for mental healthcare* section of this chapter.

Connect

If clients are experiencing toxic stress and have stress-related mental or physical health issues (see a list of ACE-Associated Health Conditions), they may be interested in connecting to resources, programs, and services that can support them in using mental healthcare as a Stress Buster to reduce stress, heal, and thrive.

Address a crisis or immediate safety issues (e.g., suicidal feelings, active abuse)	› See a list of helplines, hotlines, and crisis support at www.acesaware.org/managestress/cbotoolkit.

Find a therapist	› If the client is interested, ask if you can help them find a therapist. • Help set expectations for clients about the often long process of finding a therapist (calling, emailing, waiting to hear back, insurance issues, not taking new clients, etc.). • Clients with county Medi-Cal can call their health plans or the Medi-Cal Mental Health Care Ombudsman at (800) 896-4042 and ask for an assessment or needed services county mental health line for referrals. • Both state and federal laws require health plans to provide treatment for mental health and substance use disorder conditions. You can ask for a referral from your primary care doctor, your behavioral health care provider, or your health plan. • CA Department of Health Care Services, Mental Health Services Division can help find mental health programs and services in your area. • Therapy Project California: Current or former foster youth in California can get free teletherapy • For links to resources, see www.acesaware.org/managestress/cbotoolkit. › If the client is interested, connect them with a primary care doctor, such as an ACEs Aware-trained clinician to help them get needed interventions and referrals. › Ask clients if they would like to ask their doctor about different types of therapists, such as the following examples: • Trauma-responsive/trauma-informed: It is important to help individuals who are experiencing negative consequences of trauma to connect with mental health practitioners who are certified in at least one evidence-based trauma therapy. • Developmental and Behavioral Pediatrics (DBP): Pediatricians who specialize in DBP are trained to do assessments and provide behavioral interventions and support children and families in addressing identified behavioral concerns. Note: Many CBOs and community mental health organizations offer these assessments for free or reduced cost. To find out, contact local regional centers (www.dds.ca.gov/rc/). • Neuropsych testing/clinical neuropsychologists: Psychologists with specialized training in brain-behavior relationships can perform more detailed evaluations in addition to providing certain forms of treatment. Neuropsychological testing also can help with developing Individualized Education Plans (IEPs).[62]

Find a therapist	• Clinicians who specialize in trauma (e.g., psychiatrists, psychologists, mental health therapists): Some clinicians have expert training in trauma, including in the biological and physical effects of trauma, trauma and neurological and developmental disorders, trauma and mental health, and trauma-informed methods for treatment (e.g., Child-Parent Psychotherapy,[63] Eye Movement Desensitization and Reprocessing (EMDR), and Trauma-Focused Cognitive Behavioral Therapy[64]). • Trauma-informed psychiatrist: Provides critical support for children and adults with severe trauma symptoms, especially when they understand the biology of toxic stress. For children, it is important that psychiatrists recognize the developmental consequences of trauma, help differentiate trauma from other conditions such as ADHD, and are sensitive to issues of polypharmacy (using multiple prescription drugs). • Occupational therapy: Provides sensory and functional support including help with sensory processing and sensory integration issues. • Physical therapy: Provides movement support, improves function, and supports pain management. • Substance use specialists can help with substance use concerns. • Eating disorder specialists: Trauma can lead to a variety of unhealthy eating and food behaviors such as hoarding food, extreme binge eating, sensory processing issues, anorexia nervosa, or bulimia. These will require extra support from a mental health provider and possibly a medical specialist, or in-patient treatment. › For clients without health insurance, you can find help with Medi-Cal, health coverage, and other benefits on the California Department of Health Care Services (DHCS) website and find free primary care services at the California Association of Free and Charitable Clinics. › Clients with Managed Care Medi-Cal can call their health plans or the Medi-Cal Mental Health Care Ombudsman and ask for an assessment or needed services county mental health line for referrals. › For resources, visit www.acesaware.org/managestress/cbotoolkit.
Share online resources	› Help clients find mental health coaching, interactive tools, quizzes, and videos. › See a list of resources at www.acesaware.org/managestress/cbotoolkit.

A trauma-informed approach for mental healthcare

When we say "take a trauma-informed approach," what does that mean? There are six key principles of SAMHSA's trauma-informed approach.[65] The following table provides examples from lived experience from community partners, clinical expertise, and the literature showing how to apply this Stress Buster across the six key principles. You can follow these practices with clients who are participating in group classes or programs, or when working one-on-one with a client using Listen, Partner, Connect.

SAMHSA's principles of a trauma-informed approach	**Ways to put the principles into action** Examples from community partners, clinicians, and the literature
Safety	› Before interacting with clients, consider your own emotional state and "put your oxygen mask on first;" regulate your own strong emotions before helping others to do the same. › Help the client feel safe by speaking softly, paying full attention to them, giving them time to think and speak, and practicing active listening (see the *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients* chapter of the toolkit). › Establish emotional safety by reassuring clients that they will not be blamed for their experiences and coping responses, such as substance use.[66]
Trustworthiness and transparency	› Don't assume you know how a client is feeling. Realize that misunderstandings are especially common for children and people of color who often go unseen. Instead of saying, "I see you are feeling sad," ask: "You look upset about something. What are you feeling right now?" › Take a non-judgmental, trauma-informed approach and reduce stigma by helping clients understand mental health conditions such as depression or anxiety and what they can do to support themselves and others.[54] › Consider how best to share information about mental health with clients, such as through trusted, culturally competent messengers like promotoras. › Talk about alcohol and drug use in non-judgmental, fact-based ways.

Collaboration and mutuality	› Talk about mental health in ways that reflect your client's preferences and comfort level. For some, having a diagnosis is a helpful way to understand their symptoms and feel connected to others. For others, it can be helpful to talk about mental health not as mental illness but as mental wellness and daily feelings of well-being. You might discuss how we all can fluctuate between a wide range of mental health states during our lifetime, between wellness and illness ("mental health continuum").[67,68] › Help clients understand what they are feeling and what might be driving behavioral and mental health issues by supporting them in learning to name their emotions (e.g., Dr. Dan Siegel's "Name it to tame it"). Describing what we're feeling can help the thinking brain make sense of an experience and help the emotional brain calm down.[69] › Let clients know you are trying to understand and connect with them to collaboratively problem-solve by practicing active listening (see the *Listen, Partner, Connect: Framework and skills for a trauma-informed approach with clients* chapter of the toolkit) and repeating back for understanding.
Peer support	› Acknowledge and value clients' resilience and strengths that have enabled them to survive adversity. › Consider suggesting to the client that when people share their experiences with therapy and what they learned, they can help friends, families, and communities feel more comfortable talking about and seeking therapy. › Validate and normalize clients feeling strong emotions, such as by saying: "If you are feeling anxious, sad, or isolated, you're not alone. These feelings are common." › Recognize the importance of supportive peer relationships in helping people affected by substance use, including within families, friends, support networks, and professionals who may have shared historical, cultural, and life experiences.[66]
Empowerment, voice and choice	› Empower clients to choose if they want additional supports, such as therapy, by using motivational interviewing and collaborative decision-making. › Be aware of what words the client uses and how they are comfortable referring to a mental or behavioral health condition. Use and reflect their preferred words.[70]

Cultural, historical, and gender issues	› Recognize and honor the different cultural, historical, religious, and other customs that can influence how we can or want to engage with mental and behavioral health care. Learn about the customs of your clients and bring this learning into your conversations and programming. › Be aware that certain screening tools or diagnostic criteria may not capture mental health challenges in certain populations.[71] This includes that some individuals from certain cultural or societal contexts may not associate with terms like "stress," "anxiety" or "depression," even if they are indeed experiencing them. Similarly, some people, including those who identify as Hispanic, may, for example, describe their experiences or manifestations of symptoms or challenges in their life in somatic rather than emotional terms or concepts.[56] Terms like "anxiety" may hold different meanings by different cultures. Therefore, consider the importance of using translation services that have some expertise in the content area who can convey nuances in language. Additionally, be aware of or inquire about individual client's lived experiences rather than using unfamiliar or unrelatable terms. › Acknowledge there can be negative or fearful reactions to the idea of therapy, due to community, gender, and family culture or norms. › Explain that you can work together to find mental health services that align with clients' needs and preferences, such as with their culture, language, gender, class, national origin, and race. › Be respectful of cultural preferences around personal space and touch (e.g., hugging), recognize cultural issues around power and control, and interpret mental health symptoms and emotions in the context of culture. › Explain to clients that it's important they feel comfortable with their clinician, counselor, or therapist and they should be able to change care providers if it is not working out. › Let clients lead. Ask how clients identify and about ways to honor this in the work you are doing together.

With these tools and strategies, you can use the Stress Buster of mental healthcare to support individuals, families, and staff in preventing and treating toxic stress.

Take Stress Busters to the next level:

For ideas for integrating Stress Busters into your organization's operations, services, and physical environment, **see the chapter, *Promoting Stress Busters at the organizational level.***

References

1. Office of the Surgeon General (OSG). Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. US Department of Health and Human Services; 2021. Accessed February 10, 2025. http://www.ncbi.nlm.nih.gov/books/NBK575984/

2. CDC. About Behavioral Health. Mental Health. September 26, 2024. Accessed February 10, 2025. https://www.cdc.gov/mental-health/about/about-behavioral-health.html

3. Lebrun-Harris LA, Ghandour RM, Kogan MD, Warren MD. Five-Year Trends in US Children's Health and Well-being, 2016-2020. JAMA Pediatrics. 2022;176(7):e220056. doi:10.1001/jamapediatrics.2022.0056

4. Mental health care is in high demand. Psychologists are leveraging tech and peers to meet the need. https://www.apa.org. Accessed February 10, 2025. https://www.apa.org/monitor/2024/01/trends-pathways-access-mental-health-care

5. Lopes L, Kirzinger A, Sparks G, Stokes M, Published MB. KFF/CNN Mental Health In America Survey - Findings - 10015. KFF. October 5, 2022. Accessed February 10, 2025. https://www.kff.org/report-section/kff-cnn-mental-health-in-america-survey-findings/

6. Dube SR, Felitti VJ, Dong M, Giles WH, Anda RF. The impact of Adverse Childhood Experiences on health problems: Evidence from four birth cohorts dating back to 1900. Preventive Medicine. 2003;37(3):268-277. doi:10.1016/S0091-7435(03)00123-3

7. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. Eur Arch Psychiatry Clin Neurosci. 2006;256(3):174-186. doi:10.1007/s00406-005-0624-4

8. Petruccelli K, Davis J, Berman T. Adverse childhood experiences and associated health outcomes: A systematic review and meta-analysis. Child Abuse Negl. 2019;97:104127. doi:10.1016/j.chiabu.2019.104127

9. Hughes K, Bellis MA, Hardcastle KA, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. The Lancet Public Health. 2017;2(8):e356-e366. doi:10.1016/S2468-2667(17)30118-4

10. Rhee TG, Barry LC, Kuchel GA, Steffens DC, Wilkinson ST. Associations of Adverse Childhood Experiences with Past-Year DSM-5 Psychiatric and Substance Use Disorders in Older Adults. J Am Geriatr Soc. 2019;67(10):2085-2093. doi:10.1111/jgs.16032

11. Brown NM, Brown SN, Briggs RD, Germán M, Belamarich PF, Oyeku SO. Associations Between Adverse Childhood Experiences and ADHD Diagnosis and Severity. Acad Pediatr. 2017;17(4):349-355. doi:10.1016/j.acap.2016.08.013

12. Ashton K, Bellis M, Hughes K. Adverse childhood experiences and their association with health-harming behaviours and mental wellbeing in the Welsh adult population: a national cross-sectional survey. The Lancet. 2016;388:S21. doi:10.1016/S0140-6736(16)32257-7

13. Bellis MA, Hughes K, Ford K, et al. Adverse childhood experiences and sources of childhood resilience: a retrospective study of their combined relationships with child health and educational attendance. BMC Public Health. 2018;18(1):792. doi:10.1186/s12889-018-5699-8

14. Duke NN, Pettingell SL, McMorris BJ, Borowsky IW. Adolescent Violence Perpetration: Associations With Multiple Types of Adverse Childhood Experiences. Pediatrics. 2010;125(4):e778-e786. doi:10.1542/peds.2009-0597

15. Burke NJ, Hellman JL, Scott BG, Weems CF, Carrion VG. The impact of adverse childhood experiences on an urban pediatric population. Child Abuse Negl. 2011;35(6):408-413. doi:10.1016/j.chiabu.2011.02.006

16. Khoury L, Tang YL, Bradley B, Cubells JF, Ressler KJ. Substance use, childhood traumatic experience, and Posttraumatic Stress Disorder in an urban civilian population. Depress Anxiety. 2010;27(12):1077-1086. doi:10.1002/da.20751

17. Nelson CA, Bhutta ZA, Harris NB, Danese A, Samara M. Adversity in childhood is linked to mental and physical health throughout life. BMJ. 2020;371:m3048. doi:10.1136/bmj.m3048

18. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American journal of preventive medicine. 1998;14(4):245-258.

19. Brady KT, Back SE, Coffey SF. Substance abuse and posttraumatic stress disorder. Current Directions in Psychological Science. 2004;13(5):206-209. doi:10.1111/j.0963-7214.2004.00309.x

20. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. Arch Gen Psychiatry. 1995;52(12):1048-1060. doi:10.1001/archpsyc.1995.03950240066012

21. Leza L, Siria S, López-Goñi JJ, Fernández-Montalvo J. Adverse childhood experiences (ACEs) and substance use disorder (SUD): A scoping review. Drug Alcohol Depend. 2021;221:108563. doi:10.1016/j.drugalcdep.2021.108563

22. Hanson JL, Williams AV, Bangasser DA, Peña CJ. Impact of Early Life Stress on Reward Circuit Function and Regulation. Front Psychiatry. 2021;12. doi:10.3389/fpsyt.2021.744690

23. Lokshina Y, Nickelsen T, Liberzon I. Reward Processing and Circuit Dysregulation in Posttraumatic Stress Disorder. Front Psychiatry. 2021;12:559401. doi:10.3389/fpsyt.2021.559401

24. Hendrikse CJ, du Plessis S, Luckhoff HK, et al. Childhood trauma exposure and reward processing in healthy adults: A functional neuroimaging study. J Neurosci Res. 2022;100(7):1452-1462. doi:10.1002/jnr.25051

25. Wiss DA, Avena N, Gold M. Food Addiction and Psychosocial Adversity: Biological Embedding, Contextual Factors, and Public Health Implications. Nutrients. 2020;12(11):3521. doi:10.3390/nu12113521

26. Mate, G. In the Realm of Hungry Ghosts: Close Encounters with Addiction. North Atlantic Books; 2010.

27. Birnie MT, Kooiker CL, Short AK, Bolton JL, Chen Y, Baram TZ. Plasticity of the Reward Circuitry After Early-Life Adversity: Mechanisms and Significance. Biol Psychiatry. 2020;87(10):875-884. doi:10.1016/j.biopsych.2019.12.018

28. Roberts NP, Roberts PA, Jones N, Bisson JI. Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. Cochrane Database Syst Rev. 2016;2016(4):CD010204. doi:10.1002/14651858.CD010204.pub2

29. van Dam D, Ehring T, Vedel E, Emmelkamp PMG. Trauma-focused treatment for posttraumatic stress disorder combined with CBT for severe substance use disorder: a randomized controlled trial. BMC Psychiatry. 2013;13:172. doi:10.1186/1471-244X-13-172

30. Fortuna LR, Porche MV, Padilla A. A treatment development study of a cognitive and mindfulness-based therapy for adolescents with co-occurring post-traumatic stress and substance use disorder. Psychol Psychother. 2018;91(1):42-62. doi:10.1111/papt.12143

31. Baumer N and Frueh J. What is neurodiversity? Harvard Health. November 23, 2021. Accessed February 10, 2025. https://www.health.harvard.edu/blog/what-is-neurodiversity-202111232645

32. Kerns CM, Newschaffer CJ, Berkowitz S, Lee BK. Examining the association of autism and adverse childhood experiences in the National Survey of Children's Health: The important role of income and co-occurring mental health conditions. J Autism Dev Disord. 2017;47(7):2275-2281. doi:10.1007/s10803-017-3111-7

33. Robertson SM. Neurodiversity, Quality of Life, and Autistic Adults: Shifting Research and Professional Focuses onto Real-Life Challenges. Disability Studies Quarterly. 2010;30(1). doi:10.18061/dsq.v30i1.1069

34. Chapman R. Neurodiversity and the Social Ecology of Mental Functions. Perspect Psychol Sci. 2021;16(6):1360-1372. doi:10.1177/1745691620959833

35. Sensory issues | Autism Speaks. Accessed February 10, 2025. https://www.autismspeaks.org/sensory-issues

36. Backman C, Demery-Varin M, Cho-Young D, Crick M, Squires J. Impact of sensory interventions on the quality of life of long-term care residents: a scoping review. BMJ Open. 2021;11(3):e042466. doi:10.1136/bmjopen-2020-042466

37. Praslova LN. Autism Doesn't Hold People Back at Work. Discrimination Does. Harvard Business Review. Published online December 13, 2021. Accessed February 10, 2025. https://hbr.org/2021/12/autism-doesnt-hold-people-back-at-work-discrimination-does

38. Davis A, Solomon M, Belcher H. Examination of Race and Autism Intersectionality Among African American/Black Young Adults. Autism Adulthood. 2022;4(4):306-314. doi:10.1089/aut.2021.0091

39. Cribb S, Kenny L, Pellicano E. "I definitely feel more in control of my life": The perspectives of young autistic people and their parents on emerging adulthood. Autism. 2019;23(7):1765-1781. doi:10.1177/1362361319830029

40. Hirvikoski T, Mittendorfer-Rutz E, Boman M, Larsson H, Lichtenstein P, Bölte S. Premature mortality in autism spectrum disorder. Br J Psychiatry. 2016;208(3):232-238. doi:10.1192/bjp.bp.114.160192

41. Hirvikoski T, Boman M, Chen Q, et al. Individual risk and familial liability for suicide attempt and suicide in autism: a population-based study. Psychol Med. 2020;50(9):1463-1474. doi:10.1017/S0033291719001405

42. den Houting J. Neurodiversity: An insider's perspective. Autism. 2019;23(2):271-273. doi:10.1177/1362361318820762

43. Gilgoff R, Mengelkoch S, Elbers J, et al. The Stress Phenotyping Framework: A multidisciplinary biobehavioral approach for assessing and therapeutically targeting maladaptive stress physiology. Stress. 2024;27(1):2327333. doi:10.1080/10253890.2024.2327333

44. Sullivan ADW, Merrill SM, Konwar C, et al. Intervening After Trauma: Child-Parent Psychotherapy Treatment Is Associated With Lower Pediatric Epigenetic Age Acceleration. Psychol Sci. 2024;35(9):1062-1073. doi:10.1177/09567976241260247

45. Lanius R, Frewen P, Tursich M, Jetly R, McKinnon M. Restoring large-scale brain networks in PTSD and related disorders: a proposal for neuroscientifically-informed treatment interventions. European Journal of Psychotraumatology. 2015;6(1). doi:https://doi.org/10.3402/ejpt.v6.27313

46. Division of Violence Prevention NC for IP and C Center for Disease Control and Prevention. Essentials for Childhood: Creating Safe, Stable, Nurturing Relationships and Environments for All Children. Reprinted with major technical edits. U.S. Department of Health & Human Services, Centers for Disease Control and Prevention (CDC). Child Abuse and Neglect Prevention. 2019. Accessed January 20, 2025. https://www.cdc.gov/child-abuse-neglect/php/guidance/index.html

47. Mental wellness is important for a healthy heart and brain. American Heart Association. Accessed February 10, 2025. https://newsroom.heart.org/news/mental-wellness-is-important-for-a-healthy-heart-and-brain

48. Shields GS, Spahr CM, Slavich GM. Psychosocial Interventions and Immune System Function: A Systematic Review and Meta-analysis of Randomized Clinical Trials. JAMA Psychiatry. 2020;77(10):1031-1043. doi:10.1001/jamapsychiatry.2020.0431

49. O'Toole MS, Bovbjerg DH, Renna ME, Lekander M, Mennin DS, Zachariae R. Effects of psychological interventions on systemic levels of inflammatory biomarkers in humans: A systematic review and meta-analysis. Brain Behav Immun. 2018;74:68-78. doi:10.1016/j.bbi.2018.04.005

50. Jaffe DJ. Shortage of Psychiatric Hospital Beds for Mentally Ill (Summary TAC Report). Mental Illness Policy Org. Accessed February 10, 2025. https://mentalillnesspolicy.org/imd/shortage-hospital-beds.html

51. Yohanna D. Deinstitutionalization of People with Mental Illness: Causes and Consequences. AMA Journal of Ethics. 2013;15(10):886-891. doi:10.1001/virtualmentor.2013.15.10.mhst1-1310

52. Commentary G. After deinstitutionalization, California has tragically come full circle on mental illness treatment. CalMatters. http://calmatters.org/commentary/2023/07/california-tragically-mental-illness-treatment/. July 12, 2023. Accessed February 10, 2025.

53. Lamb HR. Deinstitutionalization and the homeless mentally ill. Hosp Community Psychiatry. 1984;35(9):899-907. doi:10.1176/ps.35.9.899

54. Why Black Mental Health Literacy Matters. HuffPost. June 19, 2017. Accessed February 10, 2025. https://www.huffpost.com/entry/why-black-mental-health-literacy-matters_b_5939b099e4b014ae8c69decf

55. Ahad AA, Sanchez-Gonzalez M, Junquera P. Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review. Cureus. 15(5):e39549. doi:10.7759/cureus.39549

56. Dunlop BW, Still S, LoParo D, et al. Somatic symptoms in treatment-naïve Hispanic and non-Hispanic patients with major depression. Depress Anxiety. 2020;37(2):156-165. doi:10.1002/da.22984

57. Stigma, Prejudice and Discrimination Against People with Mental Illness. Accessed February 10, 2025. https://www.psychiatry.org:443/patients-families/stigma-and-discrimination

58. Cognitive Behavioral Therapy (CBT): What It Is & Techniques. Cleveland Clinic. Accessed February 10, 2025. https://my.clevelandclinic.org/health/treatments/21208-cognitive-behavioral-therapy-cbt

59. Salamon M. What is somatic therapy? Harvard Health. July 7, 2023. Accessed February 10, 2025. https://www.health.harvard.edu/blog/what-is-somatic-therapy-202307072951

60. Homelessness Resource Center (HRC), SAMHSA. Motivational Interviewing: Open Questions, Affirmation, Reflective Listening, and Summary Reflections (OARS). HomelessHub. 2007. Accessed January 25, 2025. https://homelesshub.ca/resource/motivational-interviewing-open-questions-affirmation-reflective-listening-and-summary-reflections-oars/

61. Rollnick S, Miller W, Butler C. Motivational Interviewing in Health Care: Second Edition: Helping Patients Change Behavior. Second. Guilford Press; 2022. Accessed January 25, 2025. https://www.guilford.com/books/Motivational-Interviewing-in-Health-Care/Rollnick-Miller-Butler/9781462550371?srsltid=AfmBOopslyyu8bZ8G7KP8LC5EsQHBjhv5mQ1dq2l3AIiRyHhIf3sQofv

62. Schaefer LA, Thakur T, Meager MR. Neuropsychological Assessment. In: StatPearls. StatPearls Publishing; 2025. Accessed February 10, 2025. http://www.ncbi.nlm.nih.gov/books/NBK513310/

63. Lieberman AF, Van Horn P, Ippen CG. Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. J Am Acad Child Adolesc Psychiatry. 2005;44(12):1241-1248. doi:10.1097/01.chi.0000181047.59702.58

64. Seidler GH, Wagner FE. Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. Psychol Med. 2006;36(11):1515-1522. doi:10.1017/S0033291706007963

65. Substance Abuse and Mental Health Services Administration. Practical Guide for Implementing a Trauma-Informed Approach. National Mental Health and Substance Use Policy Laboratory; 2023.

66. Alcohol and drug use and trauma-informed practice: companion document - Google Search. Accessed February 10, 2025. https://www.google.com/search?q=Alcohol+and+drug+use+and+trauma-informed+practice%3A+companion+document&oq=Alcohol+and+drug+use+and+trauma-informed+practice%3A+companion+document&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBBzM0NmowajSoAgCwAgE&sourceid=chrome&ie=UTF-8

67. Peter LJ, Schindler S, Sander C, et al. Continuum beliefs and mental illness stigma: a systematic review and meta-analysis of correlation and intervention studies. Psychol Med. 51(5):716-726. doi:10.1017/S0033291721000854

68. Chowdhury R. What is the Mental Health Continuum Model? PositivePsychology.com. September 1, 2019. Accessed February 10, 2025. https://positivepsychology.com/mental-health-continuum-model/

69. Siegel D, Bryson TP. The Whole-Brain Child: 12 Revolutionary Strategies to Nurture Your Child's Developing Mind. Random House Publishing Group; 2011.

70. Nelson Al. Use Person-First Language to Reduce Stigma. Mental Health First Aid. April 12, 2022. Accessed February 10, 2025. https://www.mentalhealthfirstaid.org/2022/04/use-person-first-language-to-reduce-stigma/

71. Qué Nervios: Being Latina and Dealing with Anxiety | Anxiety and Depression Association of America, ADAA. Accessed February 10, 2025. https://adaa.org/learn-from-us/from-the-experts/blog-posts/consumer/que-nervios-being-latina-and-dealing-anxiety