TRAUMA-INFORMED PEER SUPPORT FOR PEOPLE LIVING WITH HIV

CURRICULUM TRAINER'S MANUAL

SAMHSA
Substance Abuse and Mental Health Services Administration

National Center for Trauma-Informed Care and Alternatives to Restraint and Seclusion (NCTIC)

Acknowledgments

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INTRODUCTION FOR TRAINERS

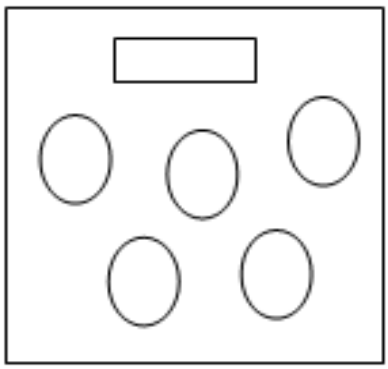
This training provides an introduction to, and overview of, key concepts in SAMHSA's technical assistance document *Engaging People Living with HIV (PLHIV) in Trauma-Informed Peer Support*: *A Guidebook*. **It is vital that you read and familiarize yourself with the entire *Guidebook* before delivering this training**.

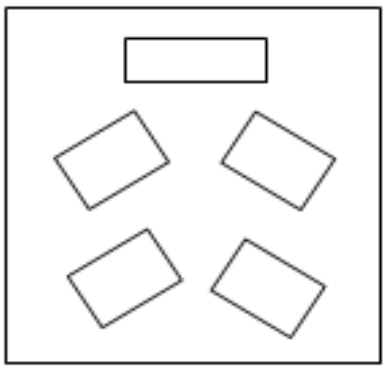
The **intended audience** for this training is people who provide peer support to PLHIV. For our purposes, "peer" is defined as someone living with HIV who uses his/her/their lived experience to support other PLHIV to survive and thrive in the community. PLHIV working in peer roles may have a variety of job titles, including HIV navigators, peer educators, community health workers, and *promoters*. They may work in paid or volunteer roles with HIV service organizations, hospitals, primary care clinics, community-based organizations, and other settings providing services to PLHIV.

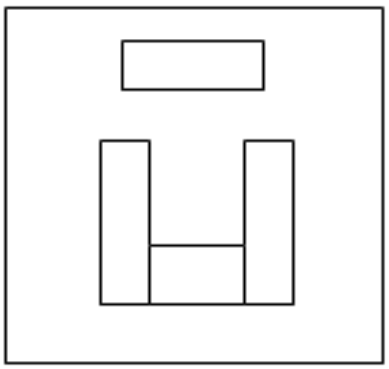
The training would also be helpful for people who receive peer support services and/or engage in peer support that is not part of a formal program, such as people who lead community-based support groups. It is also useful for anyone who works in settings where peer support is provided or who wishes to gain a better understanding of trauma-informed peer support as framed within the *Guidebook* and in this training.

This training is planned for **on full day of training**; for example: 9 a.m. to 4 p.m. with a 1-hour lunch break and one 10- to 15-minute break in the morning and in the afternoon. This is an intensive, highly interactive training that works best with groups of about **25 participants**.

Room set-up: Participants should be seated at tables in one of the configurations shown below; classroom-style seating is not recommended for this training. It's helpful to have blank wall space available for posting flip chart note pages.







PREPARATION FOR TRAINING

Before presenting this training program for the first time, it is essential that you become thoroughly familiar with all the materials, including this manual, the PowerPoint slides and notes, video clips (if used), and handouts. It is also vital that you have prior experience with and a depth of knowledge about trauma, its prevalence and impact, and trauma-informed practices.

One of the primary messages of training about trauma-related topics is that trauma can affect us in strong and enduring ways. So, in addition to having robust training skills, it is important that you have solid knowledge of trauma-related topics and self-awareness about trauma's impact on your own mind, body, and spirit. During training, both trainers and participants may be emotionally affected by the material, so it is helpful to train in teams of two, both to enable the trainers to support each other and to have a trainer available to assist participants if needed. By using techniques such as modeling trauma-informed practices during the training process, it is possible to minimize or mitigate the negative impact of trauma during training.

MODELING TRAUMA-INFORMED PRACTICES IN TRAINING

When training on topics related to trauma, it is crucial to use training approaches that are rooted in our understanding of trauma-informed practices. In *Walking the Walk: Modeling Trauma Informed Practice in the Training Environment*,[1] Leslie Lieberman identifies the following principles and discusses how to demonstrate them in training:

- **Creating safety**
  - Have participants create a self-care plan to use during the training.
  - When discussing traumatic events, give enough information to convey the idea but omit graphic details.
- **Maximizing opportunities for choice and control**
  - Let participants know they are free to choose not to participate in any activity.
  - Remind participants that they are free to leave the room if they wish.
- **Fostering Connections**
  - Provide opportunities for participants to interact with one another through discussions in pairs or small groups.
- **Self-reflection and managing emotions**
  - Offer activities that ask participants to reflect on what they have learned in pairs or on their own.
  - Build in opportunities to ask the group how an activity made them feel.

Lieberman's full article offers additional suggestions and detail, and it will be helpful to read it before conducting the training program.

The **training environment** needs to reflect the principles of trauma-informed practice and peer support**.** As discussed under "Room Set-up," above**,** it is important that participants are at tables with plenty of space between seats, that participants can see each other, and that no one is seated behind anyone else.

Each person needs a name tent—something with an inspirational quote or message can add to the experience. A well-lit colorful sensory environment helps to create comfort. This can be created by colored tablecloths, colored scented markers and paper, and quotes and pictures on the walls and tables. It is also important that participants have access to materials such as pipe cleaners, play dough, crayons, markers, and blank paper to use as they wish during the training as tools to maintain focus, to assist in staying present, and to practice self-care. Additionally, each place setting needs to be welcoming. The handout titled "The Invitation," a poem by Oriah Mountain Dreamer, is placed at each seat to welcome participants, set the tone for peer support, and add color. This poem

[1] http://www.multiplyingconnections.org/become-trauma-informed/walking-walk-trauma-informed-training

offers perspectives reflected in peer support, gives early arrivals something to read and reflect upon, and allows trainers to refer to lines from the poem throughout the training day.

SELF-ASSESSMENT

As a trainer, it is important that you have an understanding of your personal values, your biases, and your own "hot spots" related to potentially traumatizing material. This kind of self-awareness is invaluable in training and facilitating group discussion about sensitive material. To be an effective trainer, it is crucial that you:

- Identify how your own values, biases, and "hot spots" affect your behavior and communication;
- Manage your own biases and emotional responses in the training environment;
- Model respect and inclusion throughout the session; and
- Identify, use, and adapt your interpersonal skills to model trauma-informed practices for participants.

ADULT AS LEARNERS

Adults learn differently than children and teenagers do, and it is important that trainers understand these differences to be effective. The field of adult learning was pioneered by Malcolm Knowles, who identified the following characteristics of adult learners:

- *Adults are autonomous and self-directed*. They need to be free to direct themselves, and trainers must actively involve them in the learning process. Trainers must act as facilitators, guiding participants to their own knowledge rather than simply supplying them with facts.
- *Adults have accumulated a foundation of life experiences and knowledge that may include work-related activities, family responsibilities, and previous education*. Relevance is crucial to adult learning. Adults need to connect learning to their own knowledge and experience base. To help facilitate this process, trainers should draw out participants' experience and knowledge so they can relate theories and concepts to their relevant experience.
- *Adults are goal-oriented*. They appreciate a program that is organized and has clearly defined elements. It is important to demonstrate to participants how the training will help them attain their goals. Clear communication of goals and learning objectives must be done early in the session.
- *Adults are practical.* They focus on the aspects of a lesson that will be most useful to them in their work or life. They may not necessarily be interested in knowledge for its own sake. Trainers must tell participants explicitly how the training will be useful to them.
- *Adults need to be shown respect* (like all learners!). It is important for trainers to acknowledge the wealth of experiences that adult participants bring with them when they participate in training. Adult participants should be treated as equals in experience and knowledge and encouraged to voice their opinions freely.[2]

THINGS TO CONSIDER

[2] Knowles, M. (1984). *The adult learner: A neglected species* (3rd Ed.). Houston, TX: Gulf Publishing.

- *Establish your credibility in a low-key way.* At the beginning of the session, you can quietly establish your credibility in an understated way (e.g., "We've done this training for 10 other peer-run programs across the country"). But remember, this is not about you; it's about creating a positive learning experience for participants. As a trainer, you nearly always come with a certain amount of credibility, even if your name is unfamiliar to participants, so you don't need to go on about your credentials and accomplishments.

- *Recognize that straight lecture is the least effective form of learning.* People learn best when they are actively engaged. Listening is passive and requires very little engagement on the learner's part, so don't talk more than 10 to 15 minutes without doing something interactive that stimulates discussion.

- *Use the power of emotions.* People remember what they feel far more than what they simply hear or see. Use the activities in the curriculum to elicit participants' emotions. Modulate your tone of voice to accentuate the experience. Allow participants to feel their way through an exercise and ask them to reflect on how it felt.

- *Use stories to engage people in learning.* People don't always remember statistics, but they often remember stories, because stories engage their emotions. You can connect with the group by *strategically* sharing personal experiences, one of the personal stories available on video as part of the curriculum (if applicable), or stories you have heard from others that clearly relate to the point you want to emphasize.

- *Be passionate about your message.* Your passion will be infectious and will provide the emotional hook to help people remember the content of the training.

- *Engage participants by asking questions.* It is more important to ask good questions than to supply all the answers. After you ask a question, restate what you learned from the responses to ensure you understood correctly and to reinforce the points.

- *Repeat points. Say things again in a different way. Do it more than once.* Don't assume that just because you said it once, people got the message. Good trainers slip in repetition in non-redundant ways to present the idea again from a different angle.

- *Keep your training skills and your subject matter knowledge sharp and up to date.* Good presenters keep abreast of the newest training techniques and tools. You can improve upon your skills by reading on the topic, attending workshops on training techniques, watching and learning from other presenters, and/or seeking coaching from other trainers. It is equally important that you keep your knowledge of trauma-related topics current.
- *Have a quick start and a big finish*. The faster you engage participants' interest, the better. Don't bog them down with a long introduction; give them the opportunity to do something active and interesting very early. Don't let the session trail off at the end. Try to end on a high note and leave participants energized and motivated to try out their new knowledge in a concrete way.

PLANNING FOR THE TRAINING EVENT

Although every training event will be different, advance planning with the host organization should clarify the following issues:

- The organization's goals for the training.

- The extent of leadership's commitment to trauma-informed practices.

- Any previous staff training on trauma-related issues.
- This training curriculum is planned for one full day. Additional conversations or opportunities to use activities from the *Guidebook* may help increase understanding and comfort. Scheduling training to accommodate all staff will support implementation efforts.
- If you will be using online video, make sure the host organization understands that you need internet access in the training room.
- Whether the host organization or the trainer will supply and set up:
    - Projector and screen;
    - Laptop;
    - External speakers (needed if using video); and
    - Handouts.

LOGISTICS FOR THE DAY OF THE TRAINING

Plan to arrive at an hour before the presentation to ensure that:

- Your laptop is connected to the projector (if you are using your own) or the PowerPoint is loaded and the system is working properly.
- If using external speakers for video, they are working properly.
- Handouts are available in a convenient location, the room temperature is comfortable, lighting is adequate, and seating is arranged so people have easy access to exits and are not cramped.
- Art supplies and comfort materials are at each table.

SUGGESTIONS FOR TRAINERS

Some trainers or participants find it helpful to have a comfort agreement for training. Although not necessary, if used, it is recommended that this be managed with a light touch. Remember, this is training, not a support group. There may be a tendency to over-do the list-making and the group can become overly restrictive, negatively affecting learning and participation. A few simple requests may suffice, such as avoid sharing painful details of experiences, participate as much as you can, and avoid interrupting others. It is important that the trainers have the skills and experience to navigate challenges if conversations become intense.

It is important that this training be delivered **only** by trainers who are trauma survivors **and** have experience with peer support. It is also important that it be delivered by a pair of trainers, each of whom is acutely aware of the effect of trauma on their own mind, body, and spirit, and knows how to address this. Discussing trauma can bring up big emotions, so with two trainers, the one who isn't speaking can keep an eye on the emotional tone of the room and be available to step outside to support people if requested. There may also be a need for trainers to support one another if a participant is challenged by the information or their own trauma responses. Training on trauma can be draining, and splitting up and alternating the speaking time between two people helps make it more manageable for the trainers and more engaging for participants

Trainers are encouraged to use personal anecdotes or real-life examples of others' experience to illustrate key points in the curriculum to the extent that they are comfortable doing so. To model for participants and to create safety, trainers are asked **not** to relate specific painful details, as this can contribute to others' distress, but to use examples that offer the essence of the situation in a strategic way to reinforce key messages. For example, "My first abuse experience was at age 2, and I did not have words to describe that experience until I was in my

twenties." This type of example gives enough information for participants to understand the experience without the details of those events.

The training also includes handouts, exercises, and small-group discussions to ensure active participation.

USING THE SECTION-BY-SECTION AND SLIDE-BY-SLIDE GUIDANCE

The sections of the training are as follows:

1. Introduction
2. Peer support basics
3. Trauma and its impact
4. Cultural considerations
5. Trauma-informed practices
6. Trauma-Informed Peer Support
    a. Understanding self-injury
    b. Use of personal narratives
7. Reclaiming power through social action

Specific information for approaching each section is provided. The key themes for the section are highlighted, the purpose of the section is described, and guidelines for the time allotted to the section are offered.

Each slide is displayed (the full PowerPoint is included as an appendix); followed by TRAINERS' NOTE, which explains any background information needed by the presenters; followed by TALKING POINTS, which the presenter can use to further explicate and illustrate the slide content.

In addition, lists of handouts and descriptions of exercises or video clips associated with the section, or with a particular slide, are provided in text boxes throughout the instructions

A NOTE ABOUT LANGUAGE

In keeping with the values and principles of peer support, this curriculum deliberately does not use clinical language. As this training is by survivors for survivors, it does not use diagnostic terms such as PTSD (post-traumatic stress disorder) or borderline personality disorder, and it doesn't talk about clinical ideas such as "vicarious trauma" or "secondary trauma." The focus is on using everyday language to talk about people's experiences.

We also refrain from talking about "triggering" or "triggers," which can be experienced as violent terms that don't accurately describe what happens when people are emphatically reminded of traumatic events by certain words, sounds, smells, attitudes, behaviors, etc. Instead, we refer to "hot button issues," or "things that push your buttons," "things that bring up big emotions," or similar non-clinical phrases.

TRAINING INTRODUCTION (SLIDES 1-3)

Key themes: Comfort, Transparency, Equality

Section purpose: In this section, the intent is to establish comfort by introducing a warm and welcoming tone, introducing the trainers, and introducing participants to one another. The concept of transparency is briefly discussed as a key theme in trauma-informed practice. Transparency is modeled by setting expectations for the training content and explaining its origin (*Engaging Women in Trauma-Informed Peer Support: A Guidebook*), discussing the process for the day and stating the training goals.

Handouts:	Flyer—*Engaging Women in Trauma-Informed Peer Support*: *A Guidebook*
	The Invitation (poem by Oriah Mountain Dreamer)
	PowerPoint
	The Agenda

TRAINERS' NOTE:

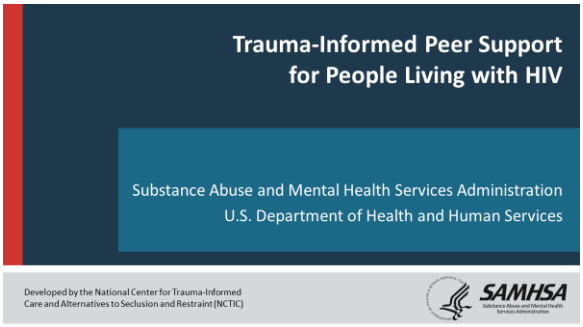
Prior to participant arrival place a copy of *The Invitation*, the flyer, and a name tent at each place setting.

Time: With arrival, settling in, and content: 20 minutes

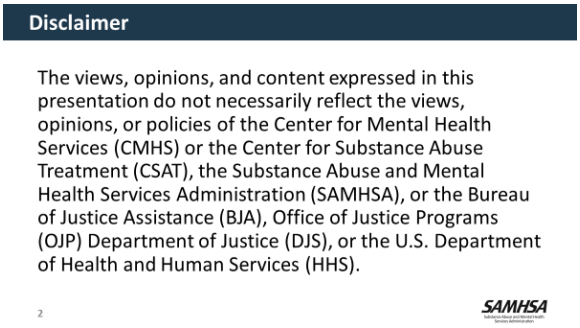
Trainers introduce themselves and review the day's agenda.

Participant introductions: Ask anyone who hasn't done so to put their name on a name tent. If scented markers are used, it is quickly discovered that they are scented and something they may use in their self-care strategies during the day. If people do not know each other, introductions may be helpful. However, trainers should model what you want people to say to avoid spending too much time and focus discussing credentials or expertise, which may imply some participants are more "recovered" or "expert" than others. One important message of this training is that we are all equals.

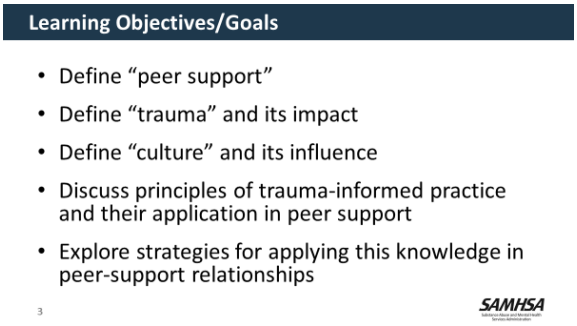
SLIDE 1: COVER SLIDE



SLIDE 2: DISCLAIMER



SLIDE 3: LEARNING OBJECTIVES



TRAINERS' NOTE:

- *Before starting, conduct an audience poll to get a sense of participants' roles and the settings in which they provide peer support.*
- *The slide lists today's learning objectives, which you will read to the audience.*
- *Transparency is a key concept in trauma-informed work. To model transparency, trainers should provide as much information as possible along the way to help participants know what to expect.*
- *The intention of today's training is to provide a brief overview of each learning objective/goal and explore strategies for applying this knowledge in peer-support relationships.*
- *We hope participants find this day helpful, no matter what setting they are in.*

SECTION 1. PEER SUPPORT BASICS (SLIDES 5-17)

SEE *CHAPTERS 3 & 9 OF THE GUIDE*

Key Themes: Peer support values, Peer relationships are different by intention, History of the movement, Mutuality, Reciprocity, Co-optation, Self-awareness, and Self-care.

Section Purpose: In this section, peer support is defined. The focus is to explain its values and principles; discuss co-optation; and talk about the essential components of self-awareness and self-care, both during the training and when practicing peer support. Trainers need to be prepared that some of these concepts will be new to participants, although most may say they participate in peer support. For example, co-optation is a term many participants will be unfamiliar with, but the concept often resonates with their experiences.

The purpose of this section is to **introduce and elaborate on the definition of peer support** that underlies the training materials and the Guide on which the training is based. There has been a proliferation of "peer specialists" and similar jobs titles in recent years, and many of these job descriptions – as well as the training and supervision that people in these jobs receive – were created by people unfamiliar with the history, values and principles of peer support that evolved out of the modern consumer/survivor/ex-patient (c/s/x) movement beginning in the early 1970s. This has resulted in various, sometimes conflicting understandings of "peer support," many of which are diametrically opposed to the traditions of the c/s/x movement.

A key point of this section is a focus on the **mutuality and reciprocity of peer support relationships**, in contrast to the hierarchical relationships that are typical in traditional programs. Peer support brings a different approach and creates space for different kinds of conversations than clinical interactions do. This ties in to ideas in subsequent sections about healing from trauma requiring a sense of safety and the rebuilding of trust, which flourish in genuine reciprocal relationships.

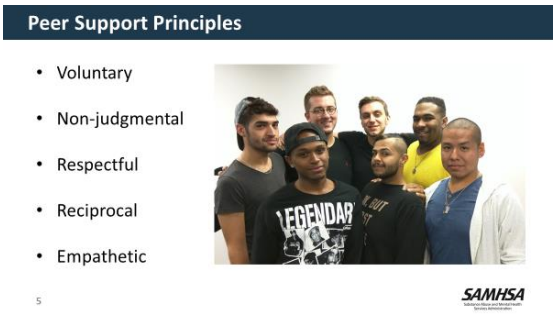
Another key point in this section is that **peer support is a non-clinical approach** to working with people, just like trauma-informed practices ask the non-clinical question "What happened to you?" rather than the clinical question, "What's wrong with you?"

This curriculum is influenced and informed by the philosophy of Intentional Peer Support (IPS) developed by Shery Mead. While "peer support" has traditionally meant informal, non-professionalized help among people who share similar experiences, IPS focuses particularly on the development of reciprocal relationships in peer support, where one person is not seen as more "recovered" or more expert than another, and there is a recognition that we all have things to share and learn from one another on our path to healing. Too often, particularly in situations where peer support staff are paid to provide services to others, it is not uncommon for people to fall back into hierarchical "helping" relationships. The "Intention" in IPS is to keep focused on true mutuality and the recognition that healing happens in connection and relationship. When peer support is offered within traditional mental health and substance disorder condition treatment and service programs, it is important for the organization to examine policies and practices that either strengthen and support or hinder peer supporters as they work. Developing strategies to sustain the people involved in this work and to ensure their colleagues understand and support their role are essential aspects of creating inclusive, trauma-informed environments.

Time: 25 minutes

SLIDE 4: TITLE SLIDE

SLIDE 5: PEER SUPPORT PRINCIPLES



TRAINERS' NOTE:

- *Transition topic to peer support basics.*
- *Because participants may have a variety of experiences with peer support, it is essential to create a shared understanding about what is meant by peer support in this curriculum.*
- *Trainers need to be prepared to offer a brief example of each principle from their own experience. There cannot be any assumption that all participants are on the same page. In fact, what is learned in the previous conversation is that there are many views about peer support.*
- *It is essential to establish these principles as the core peer support values used in this training.*
- *Review each principle and provide a brief statement or example that illustrates its meaning. Below are some examples but those from the trainer's own experiences are likely to resonate as most genuine.*
    - *Voluntary: peer support only works when everyone involved freely chooses to be involved – no one should/can be mandated to peer support.*
    - *Non-judgmental: in peer support, we don't judge how others have responded to their experiences; we are curious about how each of us has come to believe what we believe.*
    - *Respectful: we hold each person in high regard and treat each other kindly and with dignity.*
    - *Reciprocal: peer support is about building mutual relationships; each person involved is free to both give and accept support.*
    - *Empathetic: we try to put ourselves in the other person's place; we listen to each other with open minds and open hearts.*

TALKING POINTS

- These principles are drawn from Shery Mead's work on intentional peer support (*see Intentional Peer Support website at http://www.intentionalpeersupport.org/what-is-ips/*).

- **Peer support is voluntary.** The most basic value of peer support is that people freely choose to participate. It is for people who want to be involved, not people who have been told they need it or who are pressured to attend. The voluntary nature of peer support makes it easier for us to build trust and connections with one another.

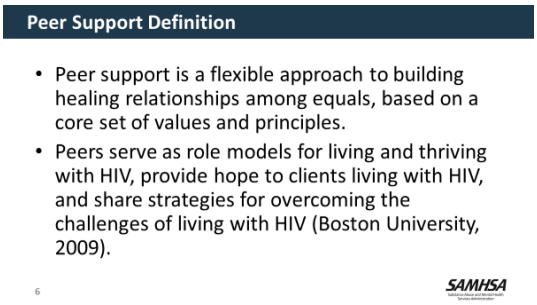
- **Peer support is non-judgmental.** In peer support, we meet people who have experiences, beliefs, or ways of living their lives that may be different from our own, despite the things we have in common. Being non-judgmental means approaching each person with openness, curiosity, and genuine interest.

- **Peer support is respectful.** Everyone is seen as having something important and unique to contribute. We value everyone who wants to be a part of the group and treat each other with kindness, warmth, and dignity. We accept each other and are open to sharing with people from many ethnicities and cultures, educational levels, and religions. We honor and make room for everyone's opinions and see each other as equally capable of contributing to the group.

- **Peer support is reciprocal.** Every person both gives and receives in a fluid, constantly changing dynamic. This is very different from what we are used to in treatment programs, where we are usually seen as people who need help and the staff are the people who give help. In peer support, we are aware that each of us has things to teach and things to learn. This is true whether you are a paid peer supporter or part of an informal group.

- **Peer support is empathetic.** Sometimes people call this "putting yourself in the other person's shoes." It means that we each make a genuine effort to imagine how the other person feels, what might have led to those feelings, and how we would want someone to respond to us in that situation.

SLIDE 6: DEFINITION



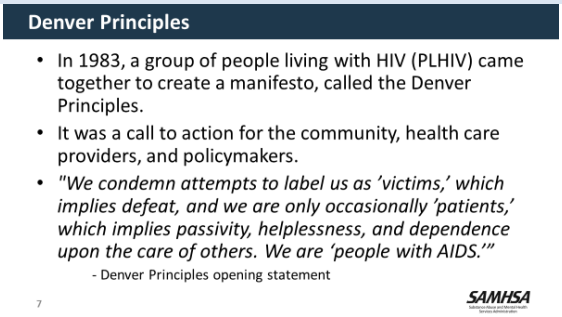
TALKING POINTS:

- People in "peer" jobs sometimes work in organizations that do not demonstrate or promote the fundamentals of peer support. They may view "peer" jobs as paraprofessional, clinically oriented roles, but peer support is non-clinical.
- The definition of peer support that we use today, and is used in these materials, comes not just from Shery Mead's book *Intentional Peer Support*, but also from the work of others as early as the 1990s in the

early consumer/survivor movement. This movement developed what was then referred to as self-help or mutual support. It grew from the recognition that people who had been disempowered by the mental health system could come together as equals and develop supportive relationships to help reclaim their power.

- In the 1980s, when little was known about HIV and discrimination was widespread, people formed small groups and risked much in order to give and get support, share knowledge, and advocate for treatment and appropriate care.
- HIV services were inspired and developed from the work of these activists and their allies in medicine, science, policy, and all walks of life, in particular the LGBT community and a young student named Ryan White and his mother. From these small beginnings emerged activism on treatment availability and cost, community advocacy, and the movements to combat discrimination and influence service delivery.
- HIV peer support has a history of challenging discrimination and advocating for trauma-informed, peer-driven services. The next slide gives more historical context for peer support and meaningful involvement of people with lived experience.
- **Reference**: Boston University, Center for Advancing Health Policy and Practice. (2009). *Building Blocks to Peer Program Success: A Toolkit for Developing HIV Peer Programs*. Retrieved from http://cahpp.org/resources/HIV-peer-program-dev

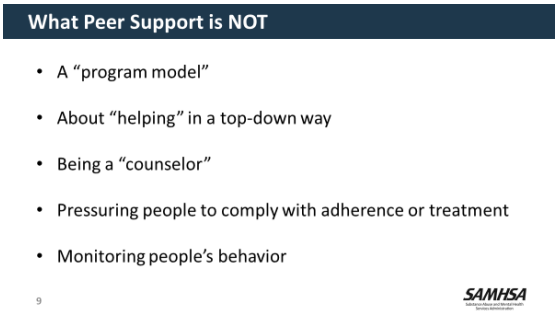
SLIDE 7: DENVER PRINCIPLES



TALKING POINTS:

- Remind participants that the Denver Principles can be found in their handouts.
- The Denver Principles, due to its historical significance, may be seen as the primary or foundational document of the HIV advocacy movement in the United States. The document demanded inclusion of the voices of PLHIV, reiterating that "nothing about us, without us."
- It outlines 17 principles that covered everything from health care decisions, to civil rights, to sexual conduct.
- Some of the language is a bit outdated, but the Denver Principles continue to be relevant today for PLHIV.
- The original activists living with HIV were inspired by the civil rights movements of the 1960s and 1970s.
- Most people who worked on the original document were white, cis-gendered gay men and lesbians. An updated version is in development to reflect the current, wide diversity of people who are PLHIV.

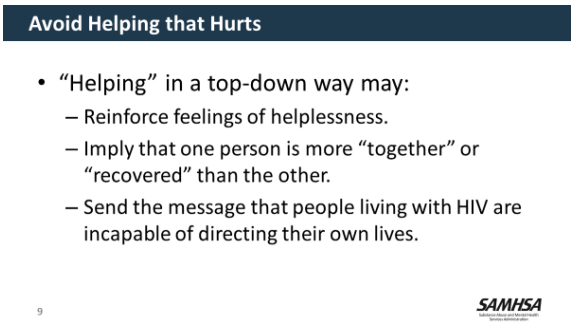
SLIDE 8: WHAT PEER SUPPORT IS NOT



TALKING POINTS:

- Peer support is about developing authentic mutual relationships, not applying a cookie-cutter approach to everyone.
- Peer supporters don't use clinical language or focus on what's "wrong" with people.
- Peer support doesn't offer top-down "helping" that disempowers people.
- "Counseling" implies that one person knows more than the other; peer support is about *power-sharing*.
- The heart of peer support involves building trust, and that isn't possible if people feel that peer support staff are acting as proxies for clinicians, case managers, or administrators, or are reporting on people's behavior.

SLIDE 9: AVOID HELPING THAT HURTS



TALKING POINTS:

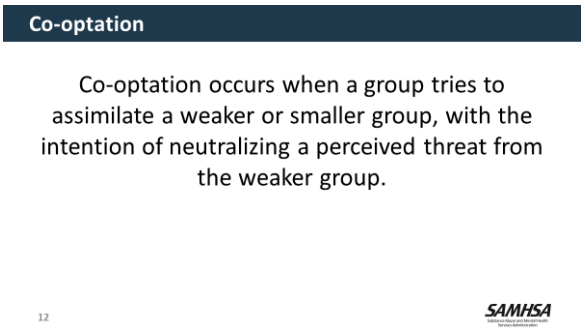
- For people in service systems, "help" has often been about things that were done <u>to</u> them, rather than <u>with</u> them, and "help" has often come from people who were authority figures who decided what "help" the person needed.
- If peer support staff act this way, it can make the other person feel "less-than" and get in the way of building trusting and mutual relationships.

SLIDE 10: PEER SUPPORT CAN FOCUS ON . . .

TALKING POINTS:

- Peer support is not just about formal support groups or one-on-one peer support relationships, nor is it solely about service navigation, although of course that can be extremely helpful.
- It can take many forms, including meeting as a group to learn something that will help people improve their lives, doing social activities together, advocating on behalf of concerns that affect people's lives, and/or becoming involved in community activities beyond the HIV care and/or mental health systems.

SLIDE 11: CO-OPTATION



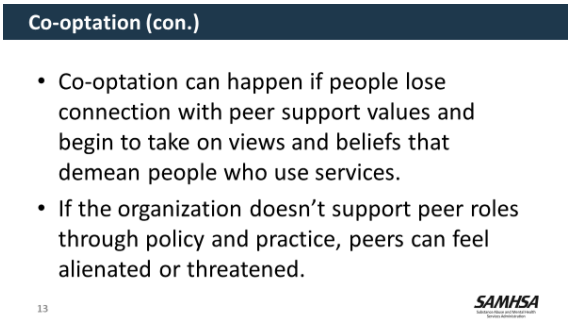
TRAINERS' NOTE:

- *Co-optation is a word that may be new to some participants. Once explained, it tends to resonate with people's experiences.*

TALKING POINTS:

- Co-optation may lead peer supporters to engage people in ways that are more typical of professional or therapeutic relationships, rather than peer support relationships.
- It can be hard to keep true to the principles of peer support when agency policies are written for non-peer staff and the agency has not developed new policies that support the unique role of peer support.
- If co- workers think of peer supporters as less valuable than other employees, resentments can build and peer supporters can feel alienated.
- The pressure to conform and fit-in can lead to self-doubt and confusion about your role.

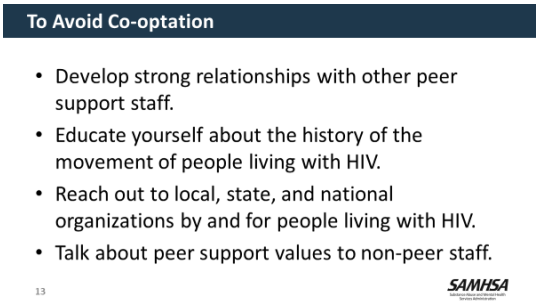
SLIDE 12: CO-OPTATION CONTINUED



TALKING POINTS:

- This is especially true when we work in environments where peer support is seen as less valuable than professional roles, or where our experiences and perspectives are different from the majority.
- It's easy to slip into a co-opted mindset if peers and organizations don't maintain an active awareness of the peer support focus.
- If your agency does not value its peer support workers, you may be uncomfortable or even ashamed of your role.

SLIDE 13: TO AVOID CO-OPTATION



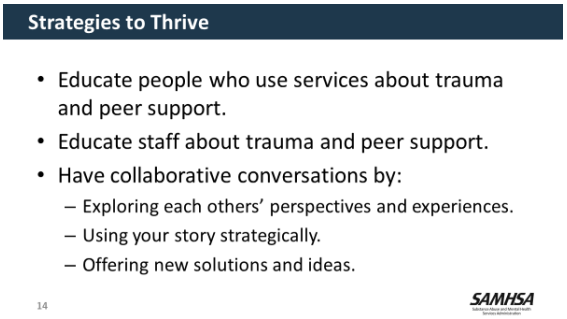
TRAINERS' NOTE:

Provide examples of problems that can arise for peer support staff when a person is the lone peer within an organization.

TALKING POINTS:

- Maintaining an awareness of the possibility of co-optation is easier if we take active steps, like these, to avoid it.
- Becoming like non-peer staff can happen simply because there is no one to compare notes with or learn from.
- You may be the only peer support worker at your organization and not know how to navigate issues that affect your ability to maintain shared power and mutuality with other people living with HIV.
- If you have a different viewpoint on a language or policy issue that is not shared by the majority, you may be intimidated to share your perspective at meetings, especially if your suggestions have been ignored or dismissed in the past.

SLIDE 14: STRATEGIES TO THRIVE



TRAINERS' NOTE:

Give participants the following scenario and ask how they would respond.

Scenario:

- **Peer supporter**: "I was wondering if we could talk about something that has come up for me around one of my job duties. It feels like there is a contradiction between helping people become independent and what I am supposed to do in my first meeting: sign them up for SSDI. Can you help me understand how our agency sees SSDI as helping people get back on their feet?"
- **Supervisor**: "Well, we feel that some of our guests have gone through so much that trying to go to work right away is setting them up for failure. We prefer to help people transition slowly."
- How would you respond?
- **Sample responses**: *"I understand that our agency wants to help women who are struggling. After a long-term hospitalization, I asked a social worker at the hospital how I was going to keep a roof over my head. I didn't have a clue about how to land a job, but I figured she could help. Instead, she told me it would be to my advantage not to work and to go on SSDI. But when I was on SSDI, the message was that I would be sick and dependent for the rest of my life."*

  "What would you think about offering people choices around SSDI or employment instead of automatically signing them up? No matter what they choose to do, it would send the message that we believe in their ability to make their own decisions and that we are here to support them to do that. I'd be happy to look at what we may need to do to create better supports for PLHIV who want to start working right away."

SLIDE 15: SELF-AWARENESS

TRAINERS' NOTE:

- Conduct Exercise: Self-care Check-In (see box)

Handout and Exercise: Self-care Check-In (Niki Miller, 2010) (slide 15) - 20 min.

Purpose: To emphasize the need for self-awareness and the responsibility for self-care when doing trauma-informed peer support, starting with practicing these skills during the training.

Process:

- *Distribute the handout "Self-Care Check-In" while slide 15 is on the screen.*
- *Introduce the activity: "*The Self-Care Check-In lists some possible strategies you can use. Please look it over and circle or fill in the blanks for the strategies that you will use if you need to. Feel free to add other strategies that work for you."
- *Read the items and give people 3 to 5 minutes to complete the form; then take 2 minutes to ask a few people to share one strategy they will use.*
- *Encourage use of peer support.*

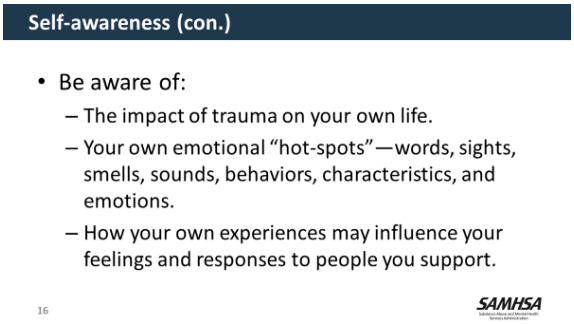
Follow-up with TALKING POINTS below.

TALKING POINTS:

- The trauma-informed approach relies on connection.
- Connecting can be hard work.
- Many providers and peer supporters have their own experiences with trauma.
- Self-care is an essential part of the foundation that sustains us in this work.

Reference:
Miller, N. (2008). *Trauma-informed Approaches in Custody Settings. NHDOC Academy Training Curriculum*. Concord, NH.

SLIDE 16: SELF-AWARENESS CONTINUES



TRAINERS' NOTE:

- *Provide a good strategic personal illustration that demonstrates a response to a hot-spot, what occurred, and the outcome.*
- *End this session by teaching a brief breathing or stretching exercise. Invite everyone to participate, in as much as they feel comfortable.*
- *Conducting a brief activity here makes it possible to wait until after the first activity in the next session to take a formal break.*

SEE CHAPTERS 1 & 2 OF THE GUIDE

Key Themes: Definition, Traumatic Events and Circumstances, Trauma's Impact, Prevalence, Healing

Section Purpose: The goals of this section are to define trauma; provide information on the way that trauma can impact the brain, body, spirit, behavior and relationships; discuss the prevalence of trauma; and explain that healing from trauma is possible.

There are many accepted definitions for trauma. The important ingredients include: stress from the shocking nature of the events and circumstances that overwhelm a person's capacity to cope, resulting in feelings of helplessness and extreme fear and horror. Threats are perceived as psychological and/or bodily violation, threat of death, or serious injury to self or a loved one. The event may be witnessed or experienced directly. The response is unique to the individual because each person has unique resiliencies and coping resources. Those resources may vary within a person depending upon life events.

The events leading to trauma responses are varied, and many survivors have experienced multiple events and circumstances that have pushed past our coping resources. Events may include experiences ranging from childhood abuse or neglect to sexual assault or domestic violence or other violent crimes experienced as an adult to socially based chronic stressors like poverty and racism. The sources of the violence may vary and leave deep and enduring wounds. A common thread is often the misuse of power by one over another.

No one can decide for someone else which experiences have caused the most harm. Deliberate interpersonal violence experienced at a young age and/or perpetrated by a trusted person or entity that is supposed to be safe is devastating. It is important for trainers to understand the pervasiveness of trauma, the overwhelming shame and rage that can accompany the experiences and the impact over the lifespan. The differences in how, if, and when people express their pain is an important concept. Often people who intend to be helpful can create disconnection by assuming they understand another's life experience, when in fact, they don't actually know what that individual's experience has been. How people experience these life events and the meaning they make of them is

an individual experience. Even the words survivors use to describe our experiences vary. For some, the word "trauma" doesn't resonate at all. During training, these differences are important to keep in mind, as it may take some participants longer to connect with the information provided.

The impact of trauma on the mind, body and spirit is explained with limited explanation of the science. There is some discussion about the body's response to threat is to signal an automatic flight, fight, or freeze response. Ordinarily, when the threat is gone, the expectation is for the body to return to baseline and relax. If ongoing threat is perceived, the body stays in a heightened state of alert and prepared for threat, a "trauma response." The Adverse Childhood Experiences Study is referenced here to point out the connections between trauma in early life and ongoing health and social challenges over the life span. Trauma leads to changes in physical and emotional arousal, attention, and perception. Survivors' responses may fluctuate between extremes (Niki Miller, 2010.) The ongoing challenges include feeling disconnected and/or powerless and having feelings and actions that are often misunderstood by service systems and others, including people who intend to be helpful.

The information in this section is provided to lay the foundation for understanding that healing is possible and peer support has the essential ingredients to assist people in their healing journey. Healing requires gaining a sense of control, feeling safe, developing trust and reconnecting to others. These components can be found in peer support.

Time: 45 minutes

SLIDE 17: SECTION TITLE: TRAUMA & ITS IMPACT

Trauma & Its Impact

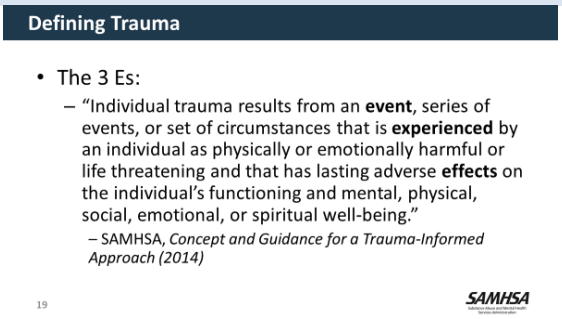
18

SAMHSA

TRAINERS' NOTE:

- *Transition topic to trauma and its impact.*
- *The initial slides provide a basic understanding to get everyone on the same page.*
- *This leads to the activity "Tracing Trauma in Your Life." The activity is designed to provide a space for participants to consider their own experiences and the language they use to describe them.*
- *It may be helpful to remind participants that as we move forward, they may want to use the self-care strategies they thought would be helpful. Trainers need to be prepared to share examples to illustrate various points to make the material as concrete as possible and to model language that makes the point about trauma without explicitly painful details.*

SLIDE 18: DEFINING TRAUMA



TALKING POINTS:

- There are many definitions of trauma.
- It is important to understand the essential themes; trauma is a response to shocking circumstances and events that overwhelm a person's capacity to cope.
- Trauma responses are individualized, because each of us has different coping resources (and the same person may have fewer/more resources at different times depending on circumstances).
- Any given threatening event may traumatize one person but not another, because trauma happens when individual feels overwhelmed by the threat.

TRAINERS' NOTE:

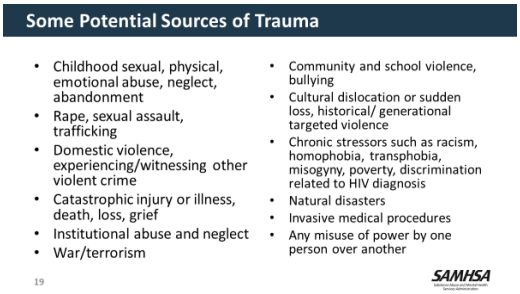
- *Offer a personal experience.*

Reference:

Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

See p. 8 of *SAMHSA's Concept and Guidance for a Trauma Informed Approach* for an expanded explanation of 3 Es.

SLIDE 19: SOME POTENTIAL SOURCES OF TRAUMA

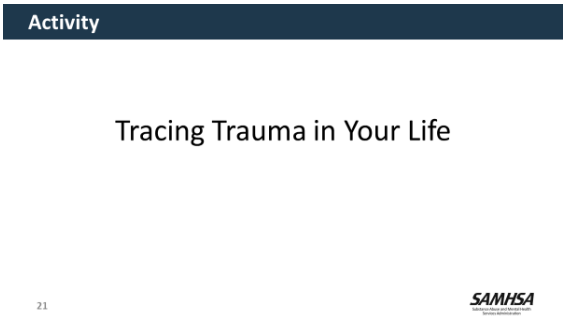


TRAINERS' NOTE:

- *These are some examples of potential sources of trauma.*

- *It is helpful to go over them by name and provide examples for things not easily understood. The upcoming activity will provide opportunity further discussion and relate this to participants' own experiences.*
- *Be sure to mention that HIV diagnosis, even though it's now a manageable condition, may be traumatic for people.*
- *Participants may have strong reactions to some of these examples. In many of the training groups, numerous people have identified having similar experiences with institutional abuse and neglect and have been surprised by seeing others in the room with a similar response.*
- *When discussing domestic violence, it may be helpful to share that children witnessing domestic violence have been traumatized by seeing a loved one harmed. It may also come up that a survivor feels they are to blame for what was done to them. It is important to state that a crime was committed against them.*
- *The culturally based trauma may require explanation. Easily recognizable examples are enslavement of African Americans, Genocide against Native Americans, and the Holocaust.*
- *The misuse of power by one person over another usually resonates with participants in a way that serves to summarize the slide and link the different experiences.*
- *Again, note that these are examples of events that are **likely** to result in a trauma response, but that people respond differently because our coping resources are different.*

SLIDE 20: TRACING TRAUMA IN YOUR LIFE



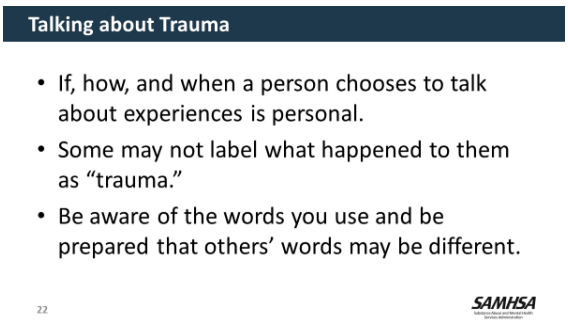
TRAINERS' NOTE:

- **Handout and Exercise: Tracing Trauma in Your Life**
- **Purpose**: *To gently explore participants' survivor experiences, confirm learning of basic concepts of different types of trauma and sources or pain, and create awareness about different perceptions of being a survivor.*
- **Process**: *Distribute the handout **Tracing Trauma in Your Life** and explain the activity. Read each trauma description and ask whether anyone wants to share or has one example of this from their life. Remind participants to try to avoid sharing extensive painful details. It is necessary for the trainer to read the description because people have different reading levels and reading comprehension skills. During this activity, it may help to manage time by asking for one example in each area and then move on to the next type of trauma. Following each response, thank the participant and acknowledge the courage it took to put their experience out in the room. It may be helpful for the co-trainer to be the first to respond and model an example of sharing an experience without painful detail.*
- **Time:** *This activity takes 20 to 25 minutes when choosing one example.*
- *When each of the six categories has been discussed, thank the participants again and ask the group to stand for a breathing or grounding exercise. Discuss that it can be challenging to share and hear about*

traumatic experiences. Refer back to the importance of self-care and remind people to use their strategies and to touch base with others during the break.

BREAK: 15 minutes

SLIDE 21: TALKING ABOUT TRAUMA



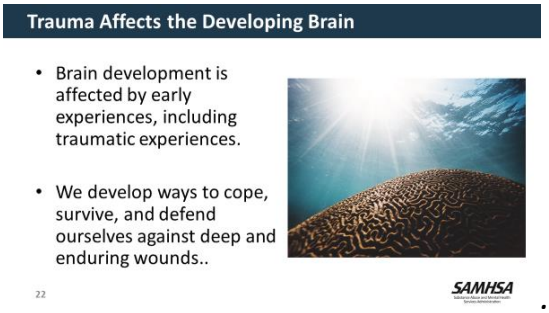
TALKING POINTS:

- This slide is about different perspectives.
- People use different language to explain their experiences.
- People have different ways of understanding what happened to them, and words may mean different things to different people.
- For example, the word *trauma* may not be in someone's vocabulary or they may have heard it on the news but not applied it to their life experience. But talking with that same person about violence in the community or asking whether they were ever hit or hurt by another person may get a different response.
- Another thing to consider is that abuse may have happened at a very young age and the survivor may not have developed language to describe the experience.
- People need to choose for themselves if, when, and where they share their truths.

TRAINERS' NOTE:

- *Examples from the trainer to illustrate these points are helpful.*

SLIDE 22: TRAUMA AFFECTS THE DEVELOPING BRAIN



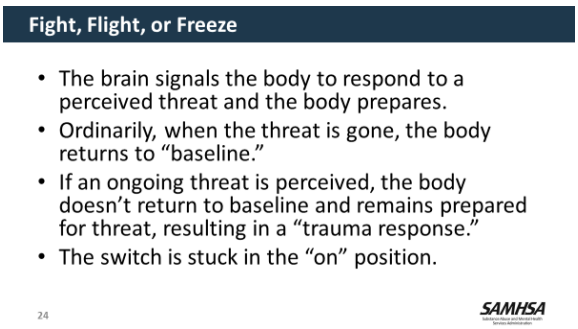
TALKING POINTS:

- Our brains are shaped by our early experiences, which includes experiences with trauma. We develop strategies to survive in that moment.

TRAINERS' NOTE:

- *Ask the group for examples of ways people learn to cope with fear and horror.*
- *It is also important to be clear that trauma is not a "brain disease." It is a natural response to adverse circumstances.*
- *It may be necessary to remind participants that trauma occurs when a person's capacity to cope is overwhelmed.*
- *Trainers can provide an example of how someone copes with extreme stress and can ask the group for an example of ways people learn to cope with fear and horror.*
- *Some examples:*
    - *Someone who experienced repeated abuse as a child has no childhood memories*
    - *A person who was frequently beaten as a child is very withdrawn and avoids social situations*
    - *A trauma survivor may act in a bristly and aggressive way to keep others at a safe emotional distance*
    - *A woman who was sexually assaulted in her own bed can only go to sleep with the lights on*

SLIDE 23: FLIGHT, FIGHT, OR FREEZE



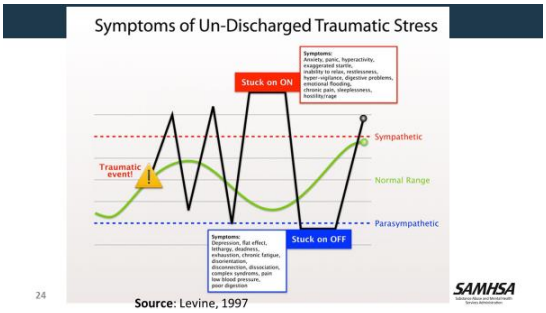
TRAINERS' NOTE:

- *This is a brief, surface-level discussion of brain processes when a threat is perceived. The point is to convey that the reactions are automatic and involuntary.*
- *Ask participants what fight might look like, what flight might look like, and what freeze might look like.*

TALKING POINTS:

- When the brain's alarm is sounded, a chemical response occurs in the brain. The brain signals the body to prepare for threat—to run, to fight, or to freeze. The body prepares by adrenalin release, pupils dilating, breathing patterns changing, etc.
- When the threat is gone, the body typically returns to baseline.
- If an ongoing threat is perceived, the body stays prepared over extended periods of time. The switch is stuck in the on position, resulting in a trauma response—always ready for threat.

SLIDE 24: SYMPTOMS OF UN-DISCHARGED TRAUMATIC STRESS



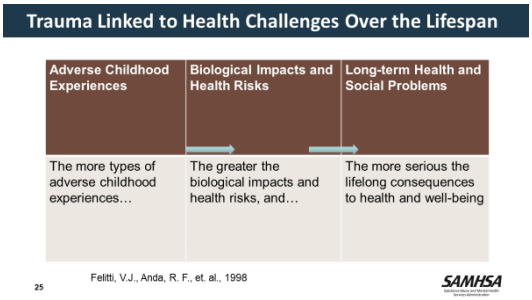
TALKING POINTS

- Peter Levine, trauma expert, says, "*Traumatic symptoms are not caused by the event itself. They arise when residual energy from the experience is not discharged from the body. This energy remains trapped in the nervous system where it can wreak havoc on our bodies and minds. . . . "* (Levine, 1997).
- None of these signs is *always* associated with trauma. However, each of these signs can be *adaptations* to the neurobiological changes associated with trauma. Even one of these signs should be enough to raise the possibility of trauma.
- Just being aware that what we sometimes call "symptoms" may be adaptations to underlying trauma can change the way we view people's behavior and responses.
- As an example, consider a woman who has experienced domestic violence and emotional abuse. One day, her trauma memories are triggered when her co-worker asks her to do something differently. The woman's response may be calm and appropriate. But due to the effect of trauma, her response may be linked to her past. So, she may:
    - Blow up and yell at the person;
    - Shutdown and become silent;
    - Walk away and refuse to discuss it;
    - Start to argue; or
    - Panic because she thinks she is a failure and is going to be fired.
- These responses may seem overblown to the co-worker who doesn't know the woman had an abusive partner who used to ridicule her, but they are all understandable responses to chronic trauma.

Reference:

Levine, P. (1997). *Waking the tiger*. North Atlantic Books.

SLIDE 25: TRAUMA LINKED TO HEALTH CHALLENGES OVER THE LIFESPAN



TRAINERS' NOTE:

- *The Adverse Childhood Experiences Study is a commonly quoted resource for understanding the long-term impact of trauma on overall health. Trainers need to be familiar with the study because many participants may have some knowledge of it and there are various views about how it is helpful.*
- *The study has limitations; the 10 categories used in the original ACE questionnaire do not include the trauma experiences of many survivors.*
- *The ACE Study also does not address trauma that happened outside of the home.*
- *More information can be found at ACESTUDY.ORG*

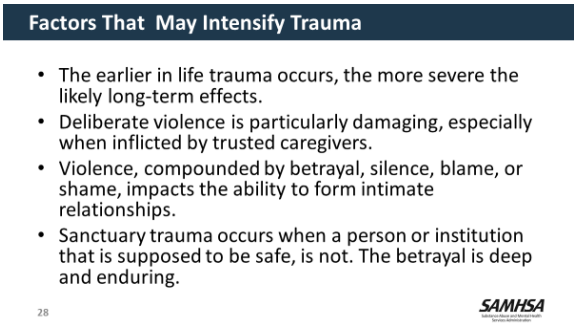
TALKING POINTS:

- The Adverse Childhood Experience Study (ACE Study) was an extensive collaboration between Kaiser Permanente Insurance Company and the Centers for Disease Control and Prevention (CDC).
- They Surveyed 17,000+ people examining the impact of negative events in early childhood on people over their lifespan.
- The ACE Score (from an ACE Questionnaire) gives a picture of the total amount of stress during childhood. As the number of ACEs increases, the risk for many health problems also increases.
- Researchers found that the adverse outcomes in health, such as lung disease, liver disease, heart disease, cancers, and alcohol and other drug use, among other health conditions, can be due to the effects of early life stress on the developing brain and the effects of a stress response system that is continually turned on. This means the chemicals in our bodies and brain that are produced as part of our stress response can also affect our bodies and brains.
- Extensive information on the ACE study is available for those seeking further information, although it is beyond the scope and time allotted for this training.

Reference:

- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . Marks, J. S. (1998). 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*, 14(4), 245-258.

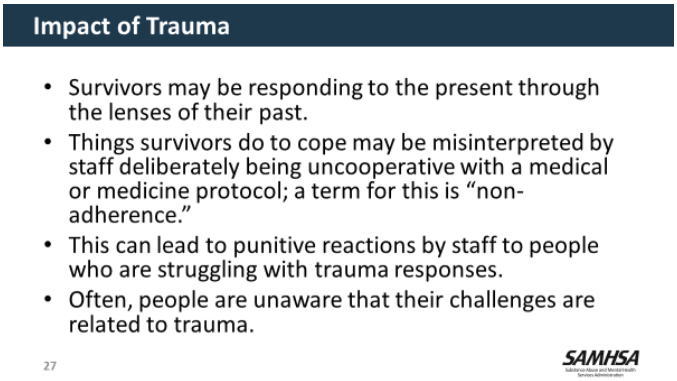
SLIDE 26: FACTORS THAT MAY INTENSIFY TRAUMA



TRAINERS' NOTE:

- *There are a few factors that contribute to survivors' coping strategies being overwhelmed. The participants may think of others.*
- *This also highlights the lasting impact shame, silence, and betrayal of trust.*
- *Sanctuary trauma occurs when a person or institution that is supposed to be safe, is not. This could include a school, medical facility, church, youth organization, etc. The betrayal is deep and enduring.*

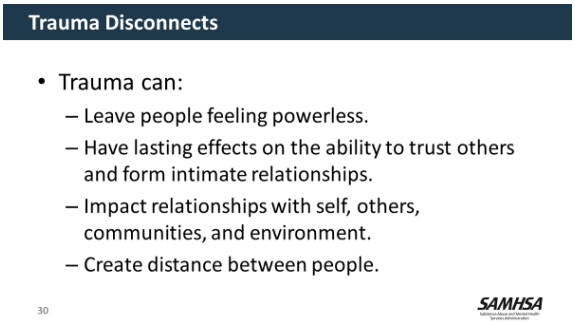
SLIDE 27: IMPACT OF TRAUMA



TALKING POINTS:

- This slide highlights the consequences when trauma is not considered, is misunderstood, or is ignored.
- Survivors may be "punished" for what staff see uncooperative or non-compliant behavior. The struggles for power as survivors try to gain or regain control can lead to labeling, restraint, and other kinds of coercion.
- Survivors and staff may be unaware that trauma is part of the picture.
- When you understand that trauma responses are involuntary, it allows for re-consideration of assumptions made about people and their behaviors. It allows for an opportunity to consider people in light of their suffering or distress, and then to think again about what might actually be helpful.

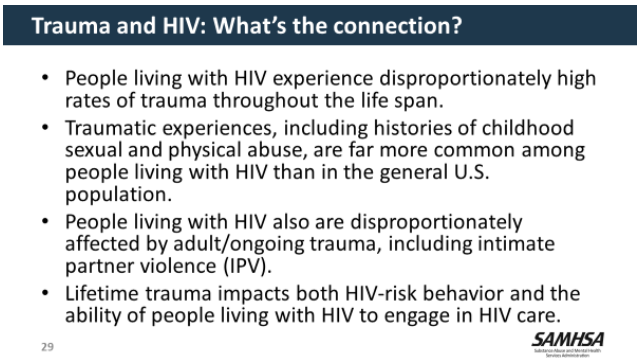
SLIDE 28: TRAUMA DISCONNECTS



TALKING POINTS:

- Trauma is often at the source of what contributes to feeling disconnected and powerless.
- The feelings of disconnection can be internal—feeling disconnected from self, and lack of connection with others, such as family, friends, neighborhood, and community.
- Another way trauma creates distance is when people in helping roles assign labels, make assumptions about behaviors (for example, "she is only seeking attention"), believe survivors do not want to heal, or shy away from or refuse to work with certain people.

SLIDE 29: TRAUMA AND HIV: WHAT'S THE CONNECTION?



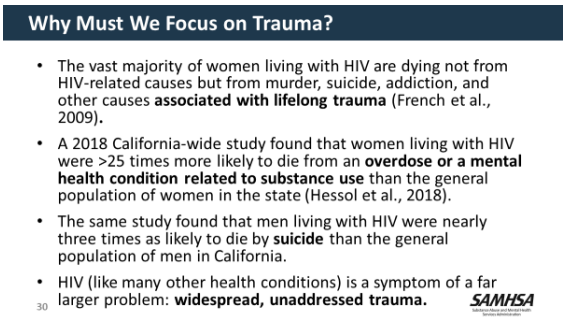
TRAINERS' NOTE:

- *It's important to understand these intersections are not the fault of the individual, but a result of structural violence in our society, the brunt of which is often borne by people of color and LGBTQI+ persons. We will talk about this more in the next slide, and then look at the impact of trauma on PLHIV.*

Reference:

- Khanna, N. & Madoori, S. (2013). *Untangling the intersection of HIV & trauma: Why it matters and what we can do*. Retrieved from http://www.gmhc.org/files/editor/file/r_ti_0913.pdf

SLIDE 30: WHY MUST WE FOCUS ON TRAUMA?



TRAINERS' NOTE:

- These findings, which come out of major long-term studies, underscore the importance of not just treating HIV, but looking at childhood and adult trauma that's impacting the health and shortening the life span of people living with HIV.
- This research is largely focused on women and less has been done across the spectrum of gender. However, we can safely assume that similar trends can be found with gay and same-gender loving men, as well as people who are transgender (Machtinger, 2016).
- **Trainers might find it helpful to review this 20-minute video presentation prior to training on this curriculum:**

  Machtinger, E. (May 2., 2016). Trauma among women: Living with HIV, understanding its rates and impact. Beyond compassion: Caring for women with a history of trauma. HIVE Symposium. Retrieved from https://youtu.be/vn_cujnoWEk

References:

- French, A. L., Gawel, S. H., Hershow, R., Benning, L., Hessol, N. A., Levine, A. M. Anastos, K., Augenbruan, M., & Cohen, M. H. (2009). Trends in mortality and causes of death among women with HIV in the United States: a 10-year study. J Acquir Immune Defic Syndr, 1, 51(4):399-406.
- Hessol, N. A., Schwarcz, S. K., Hsu, L. C., Shumway, M., & Machtinger, E. L. (2018). Gender differences in causes of death among persons with HIV/AIDS in San Francisco, California, 1996–2013. International journal of STD & AIDS, 29(2), 135-146.
- Machtinger, E. (May 2., 2016). Trauma among women: Living with HIV, understanding its rates and impact. Beyond compassion: Caring for women with a history of trauma. HIVE Symposium. Retrieved from https://hiveonline.org/wp-content/uploads/2016/06/Beyond-Compassion-Slides-Machtinger.pdf

SLIDE 31: IMPACTS OF TRAUMA ON HEALTH: STRUCTURAL VIOLENCE

TRAINERS' NOTE:

Introduce the concept of "structural violence," which may be new for people. Then take time to go around the various circles and point out how they each impact on the health and well-being of people living with HIV.
Note that this slide does not only look at structural violence. It also looks at intimate partner violence.

TALKING POINTS:

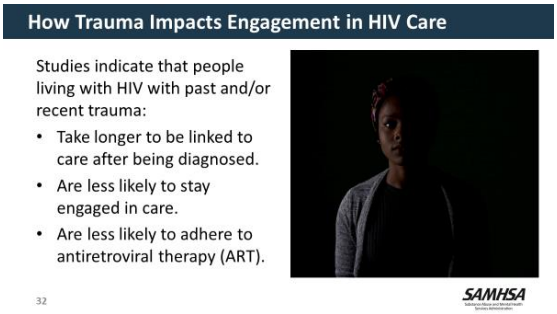
- Structural violence has been defined by as: "Preventable harm or damage . . . where there is no actor committing the violence or where it is not meaningful to search for the actor(s); such violence emerges from the unequal distribution of power and resources or, in other words, is said to be built into the structure(s)" of society (Galtung, 1969).
- Unlike intimate partner violence or other forms of interpersonal violence or one-on-one discrimination, where there is an easily identifiable perpetrator, structural violence is harder to identify.
- Structural violence can be sourced in state and federal bureaucracies, health institutions, social environments, and social and health policies that create conditions that contribute to disproportionate poor health outcomes and death among PLHIV.
- Structural violence can encompass things in these circles such as:
    - Institutional racism;
    - Homophobia, transphobia, and other stigmatizing social norms;
    - Criminalization of sex work, substance use, and HIV status;
    - Discrimination in housing, work, education, or health care; and
    - Barriers preventing people living with HIV, especially people of color and LGBTQ people living with HIV, from accessing adequate health care (Lane et al., 2004).
- Although healthcare providers can't address all of these issues in the clinic, it's important to acknowledge and understand how structural violence impact people's lives.
- It's important to build connections with community-based organizations and other services and supports than can address some of the impacts of structural violence in the lives of people you work with.

References:

- Galtung J. (1969). Violence, peace, and peace research. *J Peace Res,* 6(3),167–91.

- Lane, S. D., Rubinstein, R. A., Keefe, R. H., Webster, N., Cibula, D. A., Rosenthal, A., & Dowdell, J. (2004). Structural violence and racial disparity in HIV transmission. *Journal of Health Care for the Poor and Underserved*, 15(3), 319-335.
- Rastogi, S. (December 2012). *Integrating trauma-informed and sexual and reproductive health care in the domestic HIV response*. U.S. Positive Women's Network: Revitalizing the U.S. Domestic HIV Response. Retrieved from https://vawnet.org/material/integrating-trauma-informed-and-sexual-and-reproductive-health-care-domestic-hiv-response

SLIDE 32: HOW TRAUMA IMPACTS ENGAGEMENT IN HIV CARE



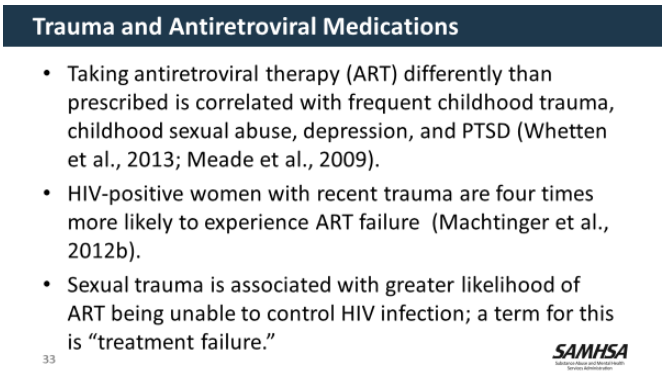
TALKING POINTS:

- Trauma and other stressful events can accelerate the progression of HIV, likely in part through compromised immune functioning,

References

- Soto, T., Komaie, G., Neilands, T. B., & Johnson, M. O. (2013). Exposure to crime and trauma among HIV-infected men who have sex with men: associations with HIV stigma and treatment engagement. *Journal of the Association of Nurses in AIDS Care*, 24(4), 299-307.
- Leserman J. Role of depression, stress, and trauma in HIV disease progression. *Psychosomatic Medicine*. 2008;70(5):539–45. Epub 2008/06/04. doi: 10.1097/PSY.0b013e3181777a5f. PubMed PMID: 18519880.
- Leserman J, Whetten K, Lowe K, Stangl D, Swartz MS, Thielman NM. How trauma, recent stressful events, and PTSD affect functional health status and health utilization in HIV-infected patients in the south. *Psychosomatic Medicine*. 2005;67(3):500–7. Epub 2005/05/25. doi: 10.1097/01.

SLIDE 33: TRAUMA AND ANTIRETROVIAL ADHERENCE



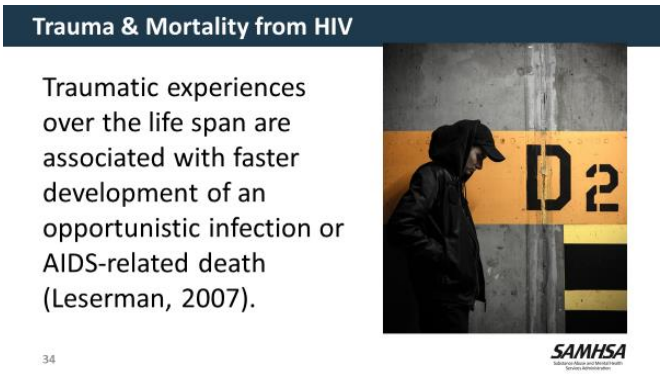
TRAINERS' NOTES:

- *These statistics show how trauma impacts people's ability to engage in care.*

References:

- Whetten, K., Shirey, K., Pence, B. W., et al. (2013). Trauma history and depression predict incomplete adherence to antiretroviral therapies in a low-income country. *PLoS One,* 8(10), e74771.
- Meade, C. S., Hansen, N. B., Kochman, A., & Sikkema, K. J. (2009). Utilization of medical treatments and adherence to antiretroviral therapy among HIV-positive adults with histories of childhood sexual abuse. *AIDS Patient Care STDS,* 23(4), 259–266.
- Machtinger, E. L., Haberer, J. E., Wilson, T. C., & Weiss, D. S. (2012). Recent trauma is associated with antiretroviral failure and HIV transmission risk behavior among HIV-positive women and female-identified transgenders. *AIDS Behav,* 16 (8), 2160–2170.
- Pence, B. W., Reif, S., Whetten, K., et al. (2007). Minorities, the poor, and survivors of abuse: HIV-infected patients in the US deep South. *South Med J,* 100(11), 1114–1122.

SLIDE 34: TRAUMA & MORTALITY FROM HIV



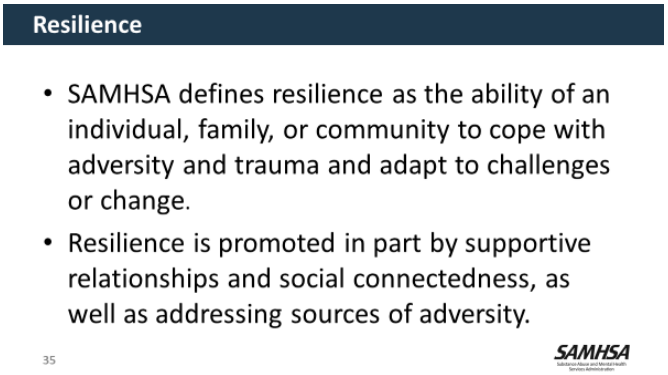
TALKING POINTS:

- Numerous studies have demonstrated the adverse impact of trauma upon the health outcomes of people living with HIV.
- Jane Leserman, Ph.D., a psychiatrist at the University of North Carolina Chapel Hill, investigated the consequences of stress and trauma in a group of 490 people living with HIV in the South.
- The number of people reporting past trauma was high—33 percent had been sexually abused, 38 percent had been physically abused, and 18 percent reported both types of abuse.
- Trauma significantly predicted risk of death from HIV or other causes.

Reference:

- Leserman, J., Pence, B. W., Whetten, K., Mugavero, M. J., Thielman, N. M., Swartz, M. S., & Stangl, D. (2007). Relation of lifetime trauma and depressive symptoms to mortality in HIV. *American Journal of Psychiatry*, 164(11), 1707-1713.

SLIDE 35: RESILIENCE



TALKING POINTS:

- When we talk about trauma, the danger is that we or the people we serve will assume that trauma is "destiny," so why even try?
- It's important to understand that adversity is not destiny.
- There are resilience factors that can lessen the impact of childhood or adult trauma at any age, and many of them are relationship-based.
- According to neuroscientist Stephen Porges and founder of the Polyvagal Theory of how humans have evolved to respond to threats in their environment, "Connection is a biological imperative."
- We also need to address the adverse conditions that people face in their lives, families, and in their communities—including violence and inequality.

SLIDE 36: THE BRAIN CAN HEAL

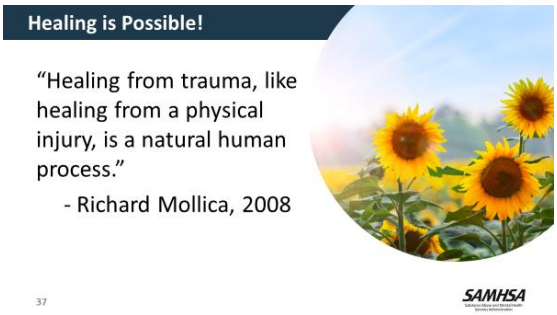
TALKING POINTS:

- Again, it's important to note that early adversity is not destiny. Although we used to think changes to the brain as a result of trauma or injury were permanent, we now know our brains are neuroplastic and can change at any age.
- According to trauma expert Dr. Celeste Campbell, "Neuroplasticity is the brain's amazing capacity to change and adapt. It refers to the physiological changes in the brain that happen as the result of our interactions with our environment. From the time the brain begins to develop in utero until the day we die, the connections among the cells in our brains reorganize in response to our changing needs. This dynamic process allows us to learn from and adapt to different experiences" (Campbell, 2009).
- There are many ways to promote the healing of a traumatized brain and body, which we will talk about more in the final section of this training.

Reference:

- Campbell, C. (2009). *What is neuroplasticity*? Retrieved from https://www.brainline.org/author/celeste-campbell/qa/what-neuroplasticity

SLIDE 37: HEALING IS POSSIBLE



TRAINERS' NOTE:

- *This slide ends this section of the training on a positive note about the importance of peer support in healing trauma.*

- *Ending the section with a breathing or stretching activity can help with the transition to the next section, Trauma-Informed Practices*.

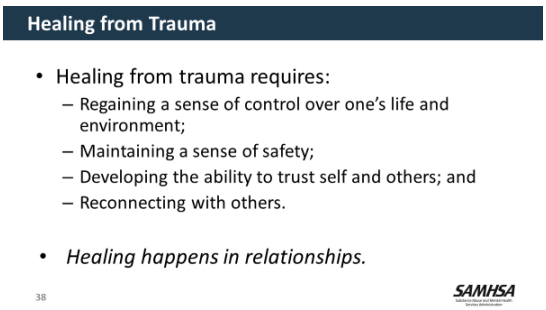
TALKING POINTS:

- Richard Mollica is a psychiatrist dedicated to working with survivors of torture from around the world.

Reference:

- Mollica, R. F. (2008). *Healing invisible wounds: Paths to hope and recovery in a violent world*. Vanderbilt University Press.

SLIDE 38



TALKING POINTS:

- Healing is absolutely possible and peer support, at its core, offers the essential ingredients to assist people in their healing journey.
- Healing requires gaining a sense of control, feeling safe, developing trust and reconnecting to others. These components can be found in peer support.

SECTION 3. TRAUMA-INFORMED PRACTICES (SLIDES 45-53)

SEE CHAPTER 3 OF THE GUIDE

Key Themes: Non-Trauma-informed Practices, Elements of Trauma-Informed Practice, Defining Help, Power, Retraumatization, Mutuality, Trustworthiness

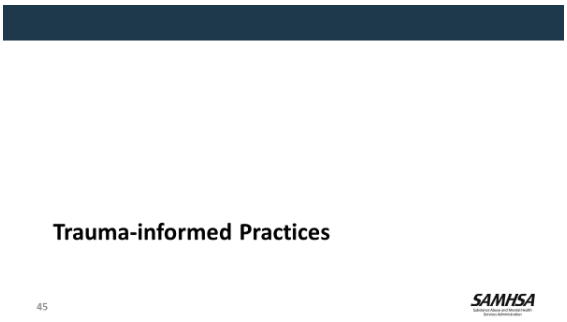
Section Purpose*:* The goals of this section are to define and describe the values, principles and implementation of trauma-informed practices, regardless of setting or service system. Trauma-informed practices are based on the universal expectation that trauma has occurred. This is sometimes referred to as "universal precautions." As survivors, many of us have found this term to be offensive, as it implies we have something to be feared or is contagious. "Universal expectation" conveys the message that anyone in any system or program, no matter their position, whether they are people who use services or staff, can be a trauma survivor.

Training participants may be familiar with some trauma-specific interventions, such as manualized treatment groups like Seeking Safety, or people may have been involved in mind/body treatments like EMDR. These treatment services work best when they are part of a larger agency-based trauma-informed approach.

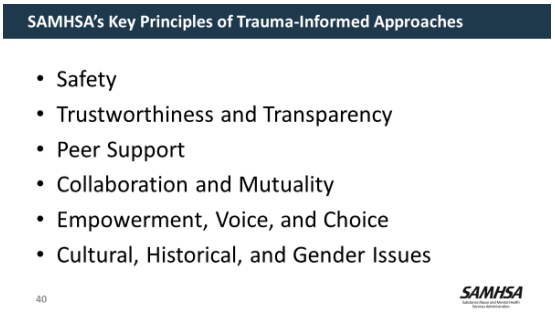
The goals in trauma-informed practices are to eliminate coercion—"do no more harm"—and to avoid revictimizing and retraumatizing people. The foundation includes the principles of safety, autonomy, voice, choice, and trustworthiness. When people work in trauma-informed ways, the focus is on supporting people in gaining what they want for themselves without force. It is important for trainers to emphasize that no one has the capacity to make someone trust in them but each of us can behave in trustworthy ways.

Time: 30 minutes

SLIDE 39: TRAUMA-INFORMED PRACTICES



SLIDE 40: SAMHSA'S KEY PRINCIPLES OF TRAUMA-INFORMED APPROACHES



TRAINERS' NOTE:

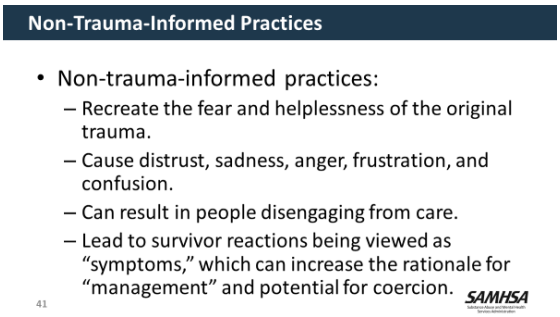
- *These principles are found in SAMHSA's Working Concept of Trauma and Framework for a Trauma-Informed Approach. The details are outlined below.*

TALKING POINTS:

- **Safety**: Throughout the organization, the staff and people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
- **Trustworthiness and transparency**: Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, service users, and family members of people being served by the organization.

- **Collaboration and mutuality**: There is true partnering and leveling of power differences between staff and people using services and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- **Empowerment**: Throughout the organization and among people served, individuals' strengths are recognized and validated and new skills developed as necessary.
- **Voice and choice**: The organization aims to strengthen service users' and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.
- **Cultural, historical, and gender issues**: The organization actively moves past cultural stereotypes and biases, offers gender-responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

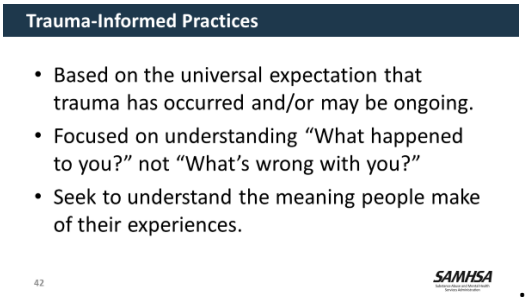
SLIDE 41: NON–TRAUMA-INFORMED PRACTICES



TALKING POINTS:

- In many mental health or other care and prevention service settings, is little or no awareness is given to the impact and prevalence of trauma among clients or staff, and the regular ways of doing business are top-down and controlling.
- This can result in a cycle of re-traumatization in which survivors react to these reminders of trauma in ways that result in staff acting in punitive or controlling ways, which increases people's distress, increases coercion, and continues the cycle.

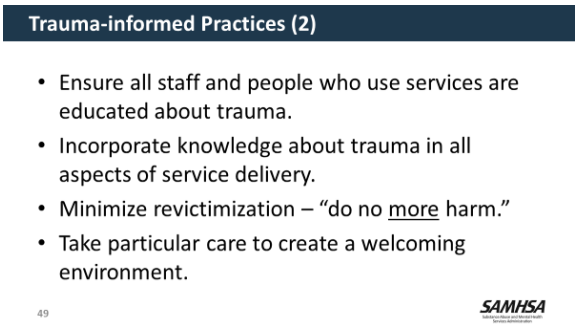
SLIDE 42: TRAUMA-INFORMED PRACTICES



TALKING POINTS:

- Knowing how prevalent trauma is among people using services, we must act on the assumption that every person we interact with is likely to be a trauma survivor, and act accordingly.
- Note that the question "What happened to you?" is not a literal question that people should be asked, but it represents the underlying philosophy of the way we interact with trauma survivors.
- Although we act on the assumption that people are trauma survivors and that something did happen to them, it's important to explore the meaning they make of those experiences and how that meaning affects their life.

SLIDE 43: TRAUMA-INFORMED PRACTICES (2)



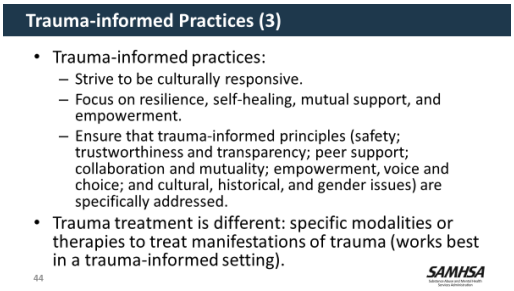
TRAINERS' NOTE:

- *It is helpful for the trainer to give some examples of "welcoming environments." The examples can include physical space, use of light and color, how to welcome people from different cultural backgrounds, providing helpful information to people who are newcomers, and conveying warmth in relationships.*

TALKING POINTS:

- Although education alone does not necessarily heal trauma, it does go a long way toward helping survivors understand what has happened to them and the long-lasting impact on body, mind, and spirit.
- Trauma-informed support offers continuous opportunities to learn about these impacts and develop new ways of coping with the range of responses previously discussed.
- There are also opportunities to create welcoming environments for staff and survivors to learn and grow in their understanding about trauma at the same time. When everyone is open to learning, there can be more power- sharing in decision-making.
- With trauma-informed practices, knowledge about trauma is reflected in all policies and practices in the organization.
- Organizations reconsider the impact of sights, sounds, and relationships. Rules are re-examined in light of how they either foster or inhibit healing. Supervision and on the job self-care practices are reexamined. Service planning approaches shift to focus on empowerment and healing.

SLIDE 44: TRAUMA-INFORMED PRACTICES (3)



TRAINERS' NOTE:

- *Present slide content and then complete the activity below.*
- *Training participants may be confused about the difference between trauma-informed approaches and trauma-specific treatment. Some examples of trauma-specific treatment include manualized group treatment models such as Seeking Safety or TREM; integrated trauma & substance use disorder treatment; mind/body approaches such as EMDR (Eye Movement Desensitization and Reprocessing.*

TALKING POINTS:

- Trauma-informed organizations rethink approaches and environments and maintain a cultural lens that is applied to services, environments, and interactions. Survivors are considered as whole people with cultural connections that need to be acknowledged and tended to as per the individual's wishes.
- People have the capacity to heal themselves when effective environments and supports are present. Mutuality and empowerment are key components of effectiveness.

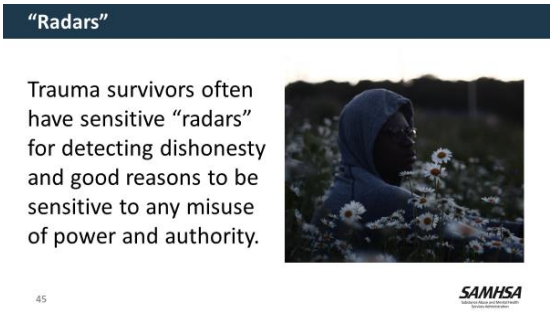
ACTIVITY: *Exploring the Principles*
***Purpose**: To engage participants in discussion and strengthen learning about the values of trauma-informed practice.*

***Process**: On the flip chart, have prepared the list "safety; trustworthiness/transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and cultural/historical/gender issues."*

Ask participants to get into groups of three to discuss the principles. Their task is to decide which of these principles is most important. Allow 10 minutes for discussion.

***Processing**: Each group reports their decision to the larger group.*
There is no right or wrong answer. It is important for the trainer to acknowledge the conversation and the consideration people have given to what they value.

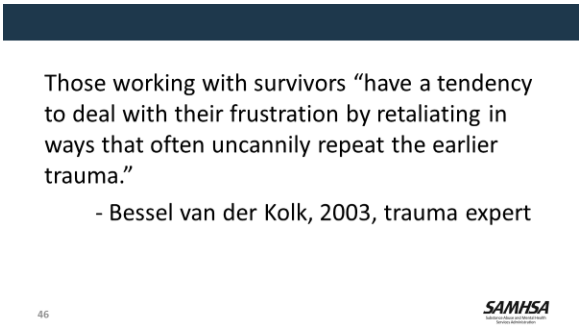
SLIDE 45: "RADARS"



TALKING POINTS:

- Many survivors have a heightened state of awareness of their surroundings and the people within them.
- When our histories contain betrayal and an inability to trust without being harmed, our healing often requires us to look for people to prove they are trustworthy before believing it to be true. In other words, "say what you mean, and mean what you say."
- Because healing from trauma requires building trusting relationships, it is crucial that in peer support we be transparent, respectful, and mutual in our relationships.

SLIDE 46: QUOTE



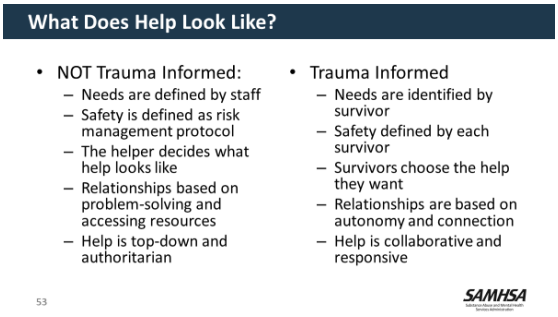
TALKING POINTS:

- This is vital to understand, especially as taking HIV correctly, other treatments, and late or missed appointments may cause providers to be frustrated.
- Responses that blame or shame an individual in any way, such as asking "why were you late?" if someone arrives late an appointment, will likely echo earlier ways in which they experienced shame or judgment from others.
- Another example in the area of inpatient mental health is when clients are subjected to practices such as seclusion or restraints in response to behavior that is often called "non-compliant." This can be extremely re-traumatizing for individuals and may cause them to avoid seeking mental health care in the future.

Reference:

- van der Kolk, B. (2003). The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics of North America*, 12(2), 293-317.

SLIDE 47: WHAT DOES HELP LOOK LIKE?



TALKING POINTS:

- This slide illustrates the differences in approach between not being trauma informed and trauma informed.
- In making the shift, there are distinct differences in philosophy and on establishing relationships based on hope and healing.

SECTION 4. CULTURAL CONSIDERATIONS (SLIDES 41-49)

SEE CHAPTER 5 OF THE GUIDE

Key Themes: Cultural Uniqueness, Culture Defined, Cultural Considerations, Group Membership, Trauma and Culture, Assumptions, Expression

Section Purpose: This section explores the incorporation of a cultural lens as part of trauma–informed practice. Culture is defined as bringing together individual components such as values, art, traditions and history, and the threads of community that bring us together as groups, such as age, gender, race. There are aspects of culture that are visible; most are invisible. Each person belongs to many different groups and no one can determine for another what group identities and group connections are more important than another.

Culture is complex, and this section just skims the surface. Trainers may want to increase their knowledge, awareness and understanding of cultural considerations beyond the scope and time of what could be covered in this section.

The focus is for participants to take a look at themselves, their values, the assumptions made about others, and the impact of culture on our capacities for healing and providing peer support. As survivors, we each experience our day-to-day lives through the lens of all of our life experiences. We carry those views into our relationships, including peer support relationships.

Participants are offered a way to reframe "cultural issues" that may get in the way of connecting and being effective and think instead about "cultural considerations." This is an invitation to think about self and others in a way that honors differences in culture and understands that history matters, and culture can shape views about illness and wellness, secret-keeping, resilience, and healing. Trauma can disconnect people from their resources and supports. Peer support can provide an opportunity for connecting and reconnecting effectively if we manage

our assumptions, understand the oppressive experiences many survivors have because of who we are, and act from that awareness. What works: curiosity, empathy and flexibility.

Time: 45 minutes

SLIDE 48: SECTION TITLE: CULTURAL CONSIDERATIONS

Cultural Considerations

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TRAINERS' NOTE:

- *This idea speaks to the concept that our experiences shape how we see the world.*
- *We can all experience the same event in this room, at this time, and each of us may be impacted differently, taking away a different view of that event.*

SLIDE 49: QUOTE

We don't see things as they are,
we see things as ***we*** are.
- Anais Nin, writer

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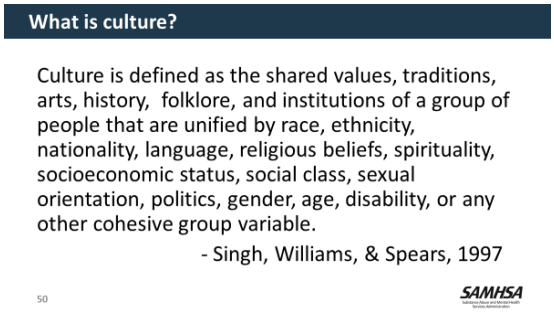
TALKING POINTS:

- This idea speaks to the concept that our experiences shape how we see the world.
- We can all experience the same event in this room, at this time, and each of us may be impacted differently, taking away a different view of that event.

SLIDE 50: WHAT IS CULTURE?



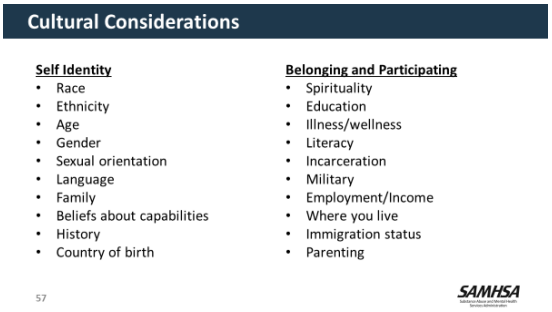
TALKING POINTS:

- There are many definitions of culture. It is important to work with one, so we have a shared understanding as a group.
- This definition describes culture as two things: first, the values, arts, history, and traditions we have; and second, what brings us together as groups.
- As humans, we belong to many different groups. It is impossible to tell what groups are important to a person without having conversations about it.

Reference:

- Singh, N. N., Williams, E., & Spears, N. (1997). Value and address diversity. *Journal of Emotional and Behavioral Disorders 5(*1), 24-35.

SLIDE 51: CULTURAL CONSIDERATIONS



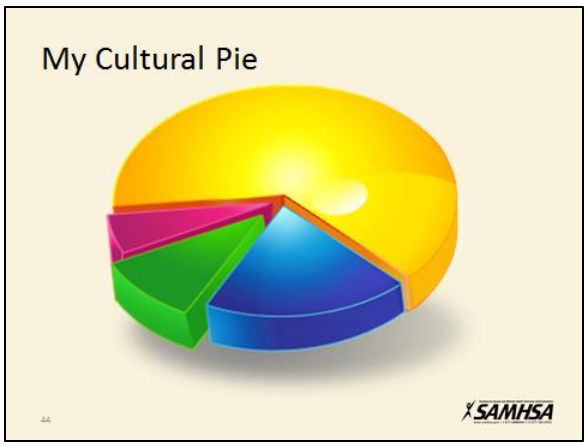
TRAINERS' NOTE:

- *Give examples of cultural groups that are personally important in your self-identification and group belonging.*

TALKING POINTS:

- This slide shares some examples of cultural considerations.
- There are aspects of culture that determine how a person identifies himself or herself.
- There are other cultural considerations that speak to how people connect to one another and where they feel they belong in their families and communities.
- It is impossible to guess or assume what aspects of culture are important to others.

SLIDE 52: MY CULTURAL PIE



TRAINERS' NOTE:

- *Conduct the activity. The handout this activity a handout of this slide.*
- *Following activity, complete the PowerPoint for the rest of this section.*

Activity: Cultural Pie ***Time 20 minutes***

Purpose: The purpose of this exercise is to guide participants to consider aspects of culture beyond race, and ethnicity, all of the cultural groups that they identify with and the importance of each group in their lives. Further, participants are engaged to examine the strengths and resources present in their "pie" and to recognize these as resiliency factors.

Process: *Say: (ignore the circle for now) Using the lines on the left side of your worksheet, make a list of all of your cultural groups. These are groups you feel a part of or identify with in any way. (Give several of your own examples; i.e. man/woman, live in the city/country/suburbs, parent, vegetarian, over 50, spiritual, military experience, Spanish- speaking)*

Allow 4-5 minutes observing the group for anyone who may need assistance to write, then move to the next part of the activity.

Say: Now using your list, imagine the circle to be a pie. I want you to assign each group on your list a slice of pie. The size of the slice depends upon the importance of that group in your life.

Allow 5-7 minutes for completion. People may struggle or ask questions. Assure them there is no right or wrong answer and however they do it is fine.

Now ask the participants to partner with someone and share how they made the decisions about their pie. Allow 5 minutes for sharing.

Process the Activity: (In a large group)

What was this activity like for you?

Did you experience any challenges? (Often someone has refused to do it. If so ask, "What led to your decision?")

Will your pie be the same in a month, in a year, 5 years?

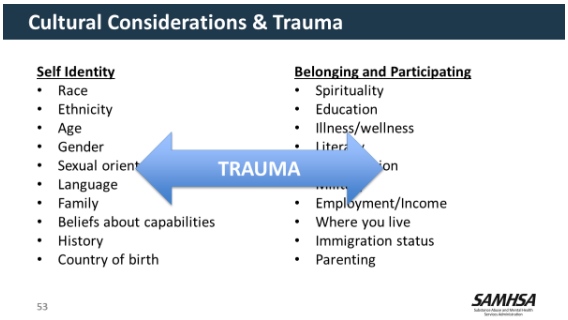
Are there strengths/resources in your pie?

What would happen if someone removed or ignored a piece of your pie?

Debrief: *Take home points:*

- Every pie is unique.
- Our culture and our lives are fluid, priorities change based upon what we are experiencing.
- Our cultural identity contains and provides inherent strengths and when we can connect with those resources, can bolster resiliency.

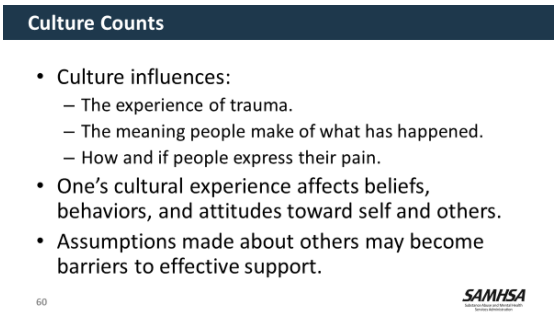
SLIDE 53: CULTURAL CONSIDERATIONS & TRAUMA



TALKING POINTS:

- Trauma can cut across all of the cultural strengths, resiliencies, and connections, often leaving people feeling disconnected and isolated.
- Survivors might not have relationships with family, or have family members, or feel part of any communities.
- Losses and betrayals might make it extremely difficult for them to feel part of groups and to form relationships.

SLIDE 54: CULTURE COUNTS



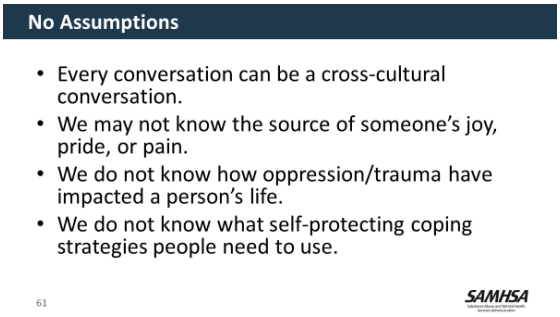
TRAINERS' NOTE:

- *Give examples from your life or experiences.*

TALKING POINTS:

- Culture counts in terms of how people experience life events, what it means to be a survivor, and the words we use to describe our experiences.
- The losses associated with trauma may be different for each survivor.
- The beliefs, biases, and assumptions we hold about others have a long, deep, individual history filled with stereotypes and inaccuracies provided by those who taught us. This can get in the way of effective peer support.
- Survivor's experiences with racism, sexism, anti-Semitism, homophobia, ableism, and classism, and any other forms of discrimination make it more difficult to trust others and often may leave a person on guard, expecting further mistreatment.

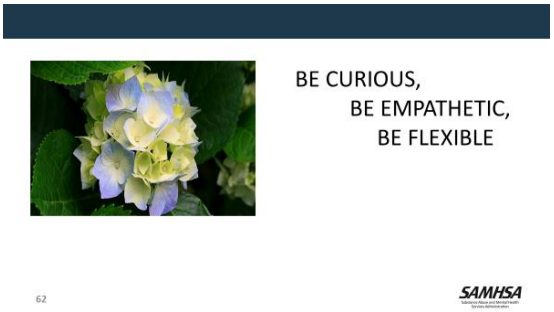
SLIDE 55: NO ASSUMPTIONS



TALKING POINTS:

- Because we do not know what cultural considerations are important until we get to know someone, be prepared that any conversation may be cross- cultural.
- Because of the nature and impact of trauma and the many potential sources of trauma, we can never assume that we know what someone's experience has been.
- We cannot assume that because we have good intentions, we are being perceived as respectful or helpful.
- It is important to understand that survivors have protected themselves from many different kinds of threat.
- Diversity among peer providers is important to provide options for connecting.

SLIDE 56: CURIOSITY, EMPATHY, FLEXIBILITY



TALKING POINTS:

- There is no shortcut to understanding.
- We need to be curious about other's lives and journeys.
- Once people have shared, we need to be empathetic. And then we need to be flexible in our approaches to mutuality and support.

SECTION 5. TRAUMA-INFORMED PEER SUPPORT (SLIDES 63-75)

SEE CHAPTERS 8, 11 & 12 OF THE GUIDE

Key Themes*:* Effective Peer Support, Coping Strategies, Defining Safety, Maintaining Integrity, Self-Inflicted Violence, Personal Narratives,

Section Purpose*:* To apply the information learned about Peer Support and Trauma-Informed Practices in earlier sections in concrete and practical ways to Trauma- Informed Peer Support.

Time: 1 hour 45 minutes (including 15-minute break, usually after slide 57)

Goals: The goals of this section are to **apply the information about trauma-informed practices presented in the earlier section specifically to the practice of peer support**. This section includes a focus on two salient topics for peer supporters: understanding self-inflicted violence and working with survivors who use this coping method, and the uses of personal narratives about trauma histories in peer support.

OVERVIEW

A key idea is that the fundamental values of peer support that were discussed in the first section of this training are enhanced by a knowledge of trauma-informed practices, and that this can help counter the negative impact of trauma. The section reinforces the idea that trauma-informed peer support works to create a safe space for people to consider the impact of trauma on their life and the possibility of adapting new coping strategies that enhance their well-being. There is a discussion of the conflicting definitions of safety often used by the system and by trauma survivors. This is followed by a focus on power dynamics and the importance of building non-hierarchical relationships in which power is shared.

SLIDE 57: SECTION TITLE - TRAUMA-INFORMED PEER SUPPORT

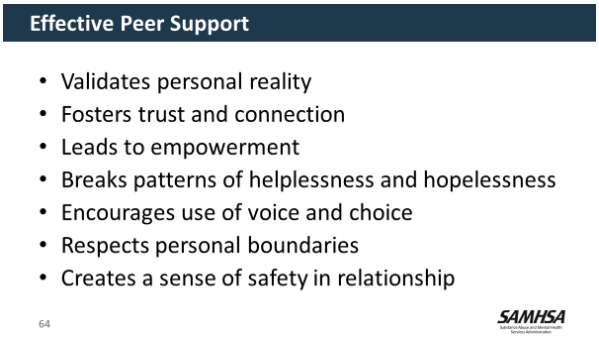
Trauma-informed Peer Support

63 SAMHSA

TRAINERS' NOTE:

- *Transition topic to trauma-informed peer support.*

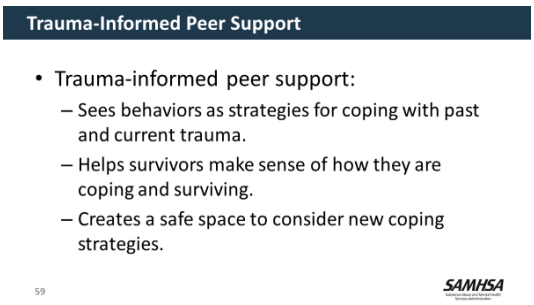
SLIDE 58: EFFECTIVE PEER SUPPORT



TALKING POINTS:

- Peer support that is based on the values and principles we discussed earlier—mutual relationships that are voluntary, non-judgmental, respectful, reciprocal and empathetic—can help survivors overcome the negative impacts of trauma and lead to the outcomes listed on the slide.

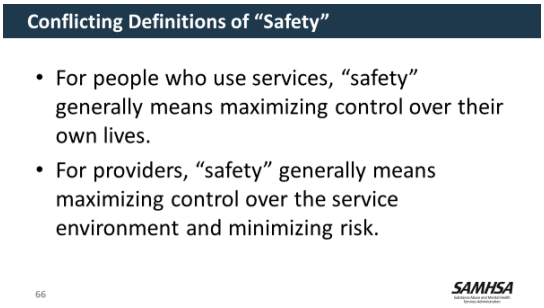
SLIDE 59: TRAUMA-INFORMED PEER SUPPORT



TALKING POINTS:

- When we do peer support in a trauma-informed way, we start with an understanding that behaviors clinicians often call "symptoms" are strategies people have developed to help them cope with the negative impacts of trauma listed on the previous slide.
- When survivors understand the impact of trauma on their lives, peer-support relationships can serve as sounding boards as they make sense of how they have managed to survive and cope with the effects of trauma.
- Trauma-informed peer support allows us to build mutual, trusting relationships that create a safe haven for people to examine their current coping strategies and try out options that may work better for them.

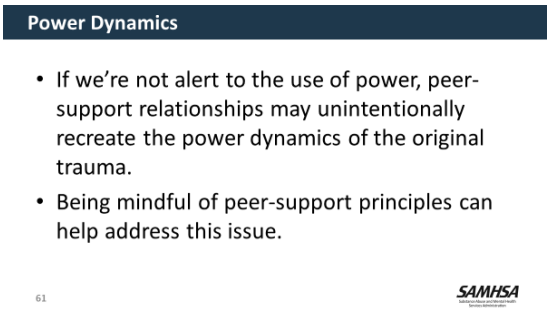
SLIDE 60: CONFLICTING DEFINITIONS OF SAFETY



TALKING POINTS:

- As we discussed earlier, reclaiming a sense of safety is essential to healing from trauma.
- Survivors need to be able to define "safety" on their own terms, and what providers call "safety" often feels anything but that to people using services.
- Peer-run programs that are trauma-informed intentionally create different approaches that align more closely with survivors' definitions of safety.

SLIDE 61: POWER DYNAMICS

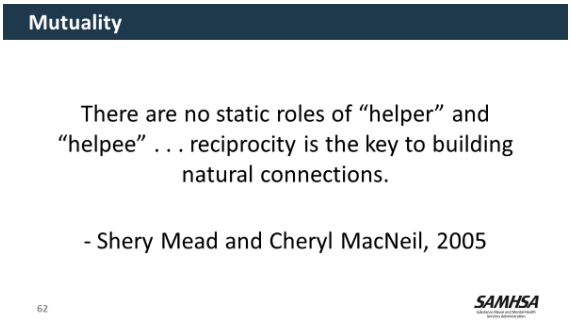


TALKING POINTS:

- Relationships between mental health professionals and people using services are often top-down and feel unequal. So it's not surprising that when people become employed as peer-support staff, they may mimic the type this type of relationship, because that's what they are familiar with and what they are used to seeing. But as we've noted, this kind of power dynamic can leave trauma survivors feeling angry and helpless.

- In trauma-informed peer support, peers strive to create the opposite of top-down by building authentic, mutual relationships in which power is shared.

SLIDE 62: MUTUALITY



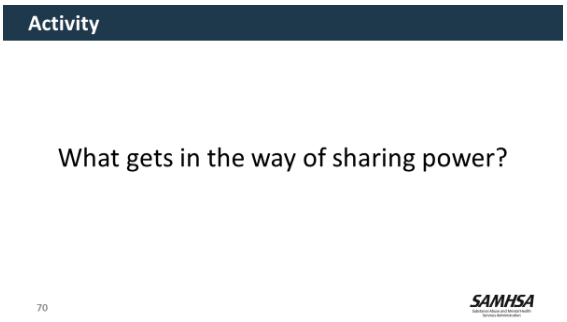
TALKING POINTS:

- According to the authors of this paper on peer support, "this is an enormous shift for people who have learned to think about community as a series of services."

Reference:

- Mead, S., & MacNeil, C. (2005). Peer support: A systemic approach. *Family Therapy Magazine*.

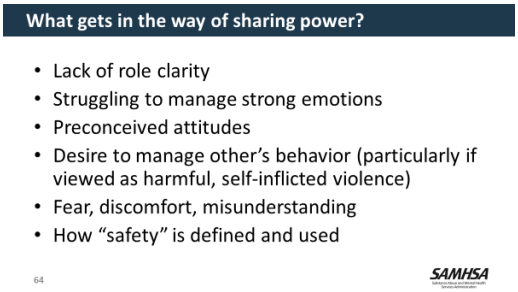
SLIDE 63: ACTIVITY - SHARING POWER



TRAINERS' NOTE:

- *Ask group for ideas about what gets in the way of sharing power in peer support relationships. Write answers on a flip chart and leave it visible during the rest of this section.*

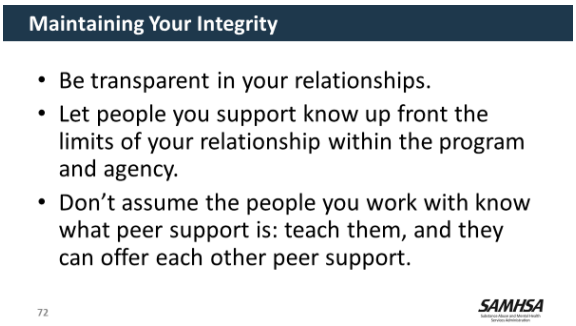
SLIDE 64: WHAT GETS IN THE WAY OF SHARING POWER?



TRAINERS' NOTE:

- *Use this slide to emphasize previous responses and address anything not brought up in the brainstorming exercise.*
- *This conversation can bring up strong emotions and spirited conversation.*
- *Following this, may be a good place for the afternoon break or a breathing exercise.*

SLIDE 65: MAINTAINING YOUR INTEGRITY



TRAINERS' NOTE:

Share Handout: **What Makes Trauma-Informed Peer Support Unique***?*

TALKING POINTS:

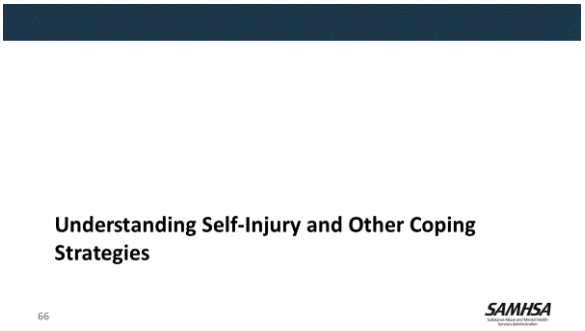
- **Transparency**:
  - Let people know about any limits to confidentiality around the information they share with you.
  - Be clear about reporting requirements you are subject to; for example, the duty to report child abuse and elder abuse or imminent harm to self or others. This will help them decide what information to share with you.
  - At the same time, help people create connections to others who can support them while keeping their information confidential, such as links to independent self-help and peer support groups that are not subject to these requirements.
- **Limits**:

  - Your agency may have policies about contact with clients outside of work hours. Talk openly about these limits and explore what your peer relationship can accomplish.
  - Provide links to others with whom people can develop meaningful connections in their communities.
  - Support their explorations of intimacy and friendship beyond the limits of the program.
- **Peer Support**:
  - Explore any assumptions the people you support may have about the nature of peer support.
  - When people identify the intent of their peer-support relationships, they begin to establish some of the ways in which peer support is different from friendship.
  - It is the intention that makes peer support what it is about—building relationships that are respectful, mutually responsible, and mutually transforming.

UNDERSTANDING SELF- INJURY (SLIDES 73-81)

This section focuses specifically on self-injury (defined as the intentional injuring of one's body as a means of coping with severe emotional and/or psychic stressors) because it is a coping mechanism used by many trauma survivors and it is the one that is most likely to result in punishment or distancing by staff or others in their lives. The intention in this section is to help people recognize self-injury as behavior that has meaning and purpose for survivors and to understand it as an expression of extreme pain rather than as "attention-seeking" or "suicidality." The focus is on creating a safe space for survivors to explore other coping mechanisms.

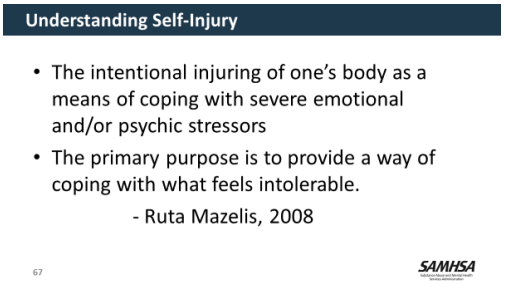
SLIDE 66: UNDERSTANDING SELF-INJURY AND OTHER COPING STRATEGIES



TALKING POINTS:

- No additional notes for this slide.

SLIDE 67: UNDERSTANDING SELF-INJURY



TALKING POINTS:

- We talk about self-injury as a part of this training because it is a coping mechanism used by many survivors and the one most likely to draw negative attention from staff.
- Staff often react to this behavior in horror, try to stop it, and punish people for engaging in it, rather than trying to understand why a person uses this coping strategy.
- Self-injury is a strategy for self-preservation rather than self-destruction. We use Ruta Mazelis' definition here to distinguish this from other harmful or risky behaviors (such as smoking, drinking, over-eating) because it is a behavior that people are often punished or ostracized for.

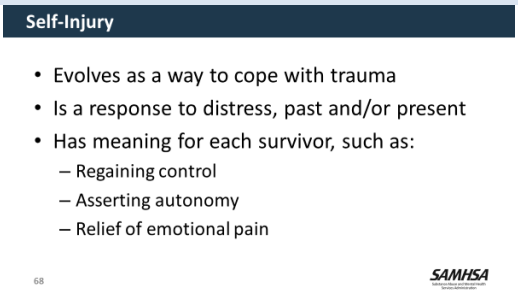
Reference:

- Mazelis, R. (2008). *Self-injury: Understanding and responding to people who live with self-inflicted violence.* Retrieved from https://www.theannainstitute.org/Self%20Injury.pdf

TRAINERS' NOTE:

- *Discuss language: we don't use the shaming and blaming language that professionals often use to describe this behavior, such as "self-mutilation."*
- *We use person-first language and don't refer to people as if their behavior defines them (i.e., "people who self-injure" vs. "cutters").*

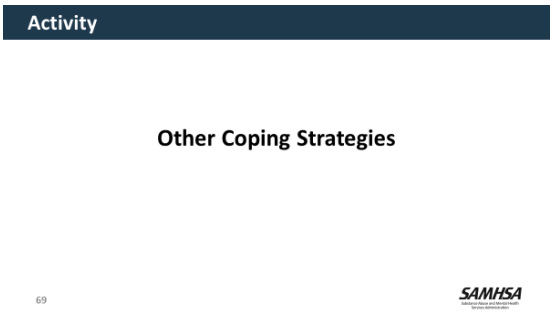
SLIDE 68: SELF-INJURY



TALKING POINTS:

- Professionals and other staff often talk about self-injury in judgmental and inaccurate ways without understanding the meaning it has for a survivor.
- It is not suicidality or "attention-seeking;" it is a often a desperate act to deal with unbearable pain.
- It's understandable that people may instinctively react to self-injury with fear or horror, but it's important to take a step back and understand the purpose this may serve for a person in extreme distress. Only if we don't judge people for the behavior is it possible to earn their trust and create a safe space for them to consider other coping strategies, if that makes sense to them.

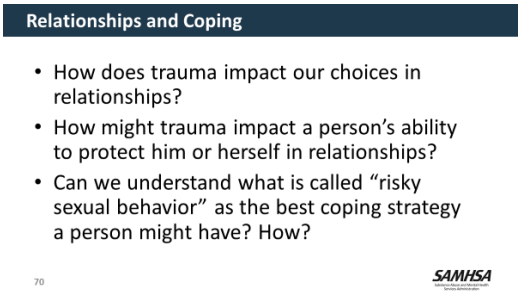
SLIDE 69: ACTIVITY – OTHER COPING STRATEGIES



TRAINERS' NOTE:

- *Have participants break into small groups to discuss various ways in which people cope with stress and trauma.*
- ***Purpose**: The purpose of this activity is to get participants thinking of the variety of coping behaviors that people use beyond self-injury.*
- ***Activity**: Come up with a few examples to get participants started. Examples could include:*
    - *Using drugs, alcohol, food*
    - *Sex*
    - *Relationships with inappropriate people*
    - *Shoplifting*
    - *Shopping*
    - *Gambling*
    - *Netflix/TV bingeing*
    - *Internet surfing*
    - *Candy Crush*
- *Wrap up the activity by emphasizing that some of these behaviors are more socially acceptable than others, and some can get us into more "trouble" than others, as a transition to the next slide.*

SLIDE 70: RELATIONSHIPS AND COPING



TRAINERS' NOTE:

Ask participants to answer the questions. Answers could include:

- *Trauma can interfere with developing healthy connections with self and others.*
- *Those of us with a history of trauma, especially if there were no role models for healthy boundaries and sexuality, may engage in behavior that puts us at risk for contracting HIV.*
- *A history of trauma can impact people's ability to protect themselves sexually.*
- *People with trauma histories may engage in sexual behavior that puts them at risk for transmission of HIV.*

Read this quote from an HIV-positive survivor:

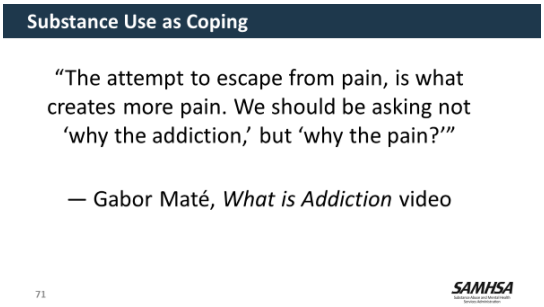
So I got into heavier drugs in high school and I would have lots of sex partners—I was just trying to find that love in my life and acceptance . . . So I would have sex at the drop of a dime . . . And along with that came those partners that beat you and want to control you, and I accepted all that 'because I thought it was love. I thought that men that put their hands on you, if you didn't do that, you didn't love me . . .

~ Jay B.

Reference:

- The Well Project: http://www.thewellproject.org/hiv-information/trauma-and-hiv

SLIDE 71: SUBSTANCE USE AS COPING

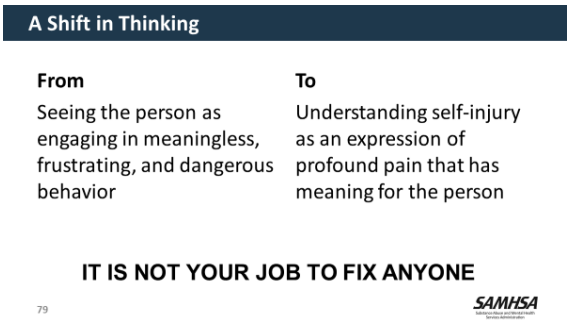


TALKING POINTS:

- Gabor Mate, an international expert on addiction, says in his book *In the Realm of the Hungry Ghosts:* "Not all addictions are rooted in abuse or trauma, but I do believe they can all be traced to painful experience. A hurt is at the center of all addictive behaviors. It is present in the gambler, the Internet addict, the compulsive shopper and the workaholic. The wound may not be as deep and the ache not as excruciating, and it may even be entirely hidden—but it's there."

Optional: Show 3-minute video "What is Addiction" by Gabor Mate:
https://www.youtube.com/watch?v=T5sOh4gKPIg

SLIDE 72: A SHIFT IN THINKING



TALKING POINTS:

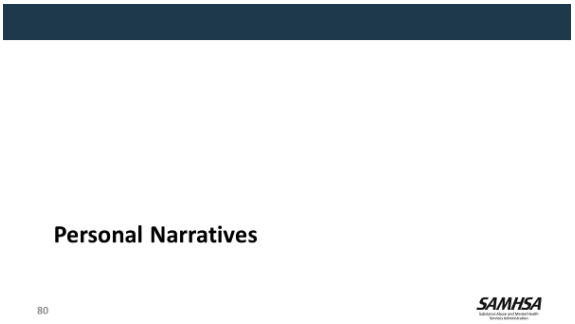
- To do effective peer support with someone who uses self-injury as a means of coping, we might need a change in how we think about this behavior.
- We also need to examine our own feelings and reactions about this, and make sure we don't shame people who use this coping mechanism.

PERSONAL NARRATIVES (SLIDES 80-88)

This section addresses how survivors can use their personal narratives to organize their understanding of their experiences and use that understanding in their healing, and how trauma-informed peer support can help that process. We deliberately use the term "personal narrative" instead of "story," as "story" may imply something that is made up, and trauma survivors are often not believed when they tell what happened to them.

Key ideas include the fact that the meaning people have made of their experience is fundamental to healing from trauma; that personal narratives can be told in ways other than through talking; and that telling one's narrative is a personal choice and is not necessary for healing. This section also discusses how peer supporters can use excerpts from their own narratives strategically to provide people with helpful examples in ways that don't re-traumatize them.

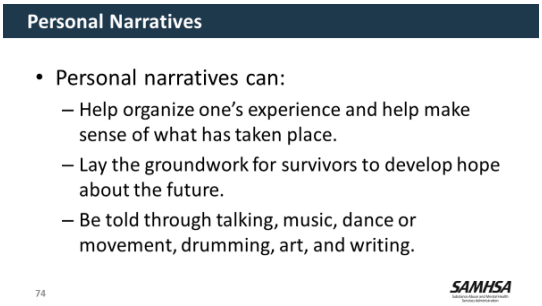
SLIDE 73: PERSONAL NARRATIVES



TALKING POINTS:

- Using survivors' personal narratives within the context of peer-support relationships can be a powerful tool for healing, as long as it's done in a trauma-informed way.
- We chose to use the term "personal narrative" rather than "story," because "story" can imply something that's made up, and trauma survivors are often not believed when they tell what's happened to them.

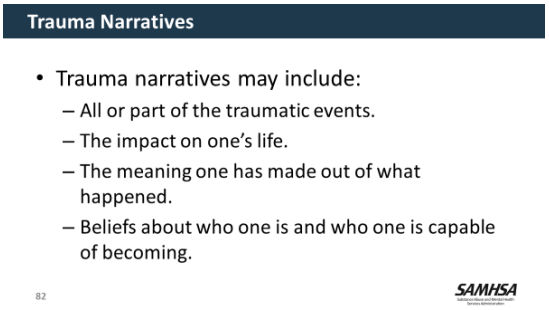
SLIDE 74: PERSONAL NARRATIVES



TALKING POINTS:

- Our personal narratives can be helpful in several ways. First, they help people mentally and emotionally organize what's happened, and helps them discover the meaning they attach to their experiences. Often just by telling the narrative, people remember new pieces of it and uncover new meanings.
- Through narratives, people can often see their own strengths more clearly and understand how they've survived and how they can continue to move forward.
- Narratives don't have to be told in words. People can tell their narratives in ways that feel most natural, including painting, drawing, writing, dance or movement, drumming, music, and so on.

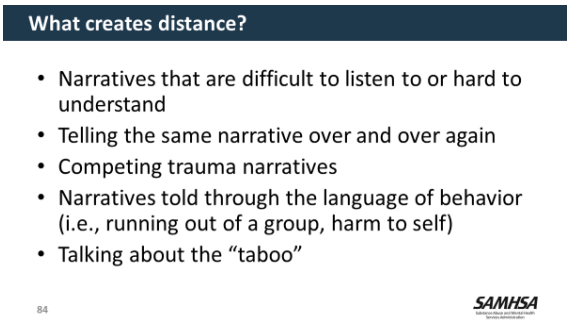
SLIDE 75: TRAUMA NARRATIVES



TALKING POINTS:

- No additional notes for this slide.

SLIDE 76: WHAT CREATES DISTANCE?

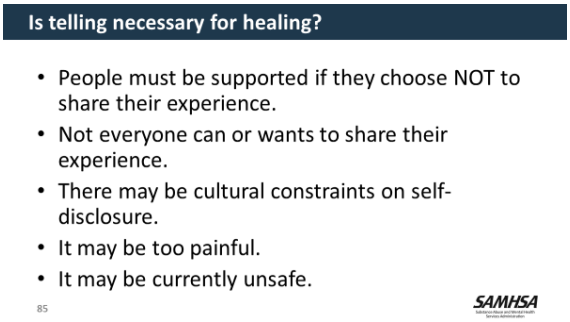


TALKING POINTS:

- Sometimes, narratives can create distance between a survivor and a person providing peer support. If we're aware of this possibility, we can take steps to mitigate that.
- Narratives may be hard to hear if the listener is overwhelmed by the painful details of the story. It's not always necessary to tell these "gory details."
- Sometimes narratives can be hard to understand because survivors are still struggling to make sense of their experience and it comes out in an incomplete or non-linear way
- It can be hard to hear the same story over and over, but sometimes people feel compelled to tell the story again and again before they can move on.
- People in groups sometimes try to out-do each other with the horror of what happened to them (e.g., "You think that's bad, you should hear what happened to me!"). It's important to let people know that trauma narratives are not competitions in topping each other; they must be heard in a respectful manner without judgment.
- Narratives are sometimes told through the language of behavior. For many people, trauma is literally *unspeakable*. This failure of words can create a need for communication based on behavior.
- For example: A woman runs out of your peer support group after she got close to painful or distressing feelings. Even though she is no longer present, she is still communicating powerful messages. What is going on, and how do we support a different way of telling the story? Instead of dismissing what this woman is doing as "acting out," although this behavior may be disruptive, it is an attempt to say something important. Language is not just what one says, but also what one does. What she does may be her best attempt to explain who she is and what she knows.

- Talking about the taboo: In the case of violence and abuse, the internal experience can be devastating, creating a sense of shame, humiliation, embarrassment, and dread. These feelings are hard to talk about and hard to listen to. It is not just the abuse that can separate a survivor from others, but also the tragic meaning she has made out of the experience: I am damaged. I must not let anyone know. Similarly, trauma survivors who have been violent to others, including their own children, are often extremely isolated and face great internal shame. Care should be taken to create safe space to explore taboo areas of their lives, especially for those who have perpetrated violence in the past and now seek help through peer support.
- We need to recognize that many people have never felt safe telling what happened, and it can be very hard for them to do that for the first time. It takes courage and a setting where they feel safe.

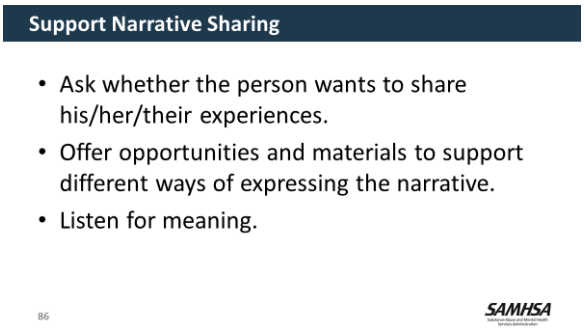
SLIDE 77: IS TELLING NECESSARY FOR HEALING?



TALKING POINTS:

- Sharing one's personal narrative is a choice, and it is not necessary to tell one's story in order to heal.

SLIDE 78: SUPPORT NARRATIVE SHARING



TALKING POINTS:

- Don't make sharing an expectation; make it an invitation.
- Make sure people have access to art supplies, paper to write on, drums, and other musical instruments, etc., as alternative ways to express their narrative.
- The meaning people make of their experiences is more important than the details of their narratives. Once they understand the meaning they've made of the past, they can explore other meanings that may be more self-affirming.

SECTION 7. RECLAIMING POWER THROUGH SOCIAL ACTION (SLIDES 70-74)

SEE CHAPTER 13 OF THE GUIDE

Key Themes: Social Action is Healing,

Section Purpose: To illustrate that taking social action can help survivors heal in community

Time*:* 15 minutes

The closing section of this training ends the training on a positive note by describing how trauma survivors can come together to help others and promote social justice as they heal from trauma. The key points here are that trauma often leaves survivors angry, disconnected and feeling helpless, and that coming together with others to organize for social action can address these issues on an individual level, while building community and working for a cause that is bigger than oneself. People don't need to wait until they're "recovered" to do this – the activity itself is healing. Close by asking participants to consider whether social action could be healing for them and what type of action appeals to them.

SLIDE 79: TITLE SLIDE - RECLAIMING POWER THROUGH SOCIAL ACTION

Reclaiming Power through Social Action

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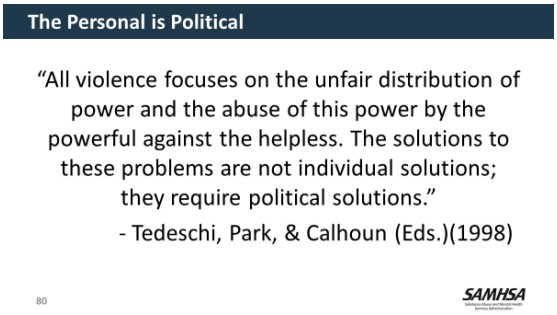
TRAINERS' NOTE:

- Transition topic to reclaiming power through social action.

Handout: **Social Action Principles for Trauma Survivors**

SLIDE 80: THE PERSONAL IS POLITICAL



TALKING POINTS:

- *This quote illustrates the point that trauma is not something that affects individuals in isolation.*

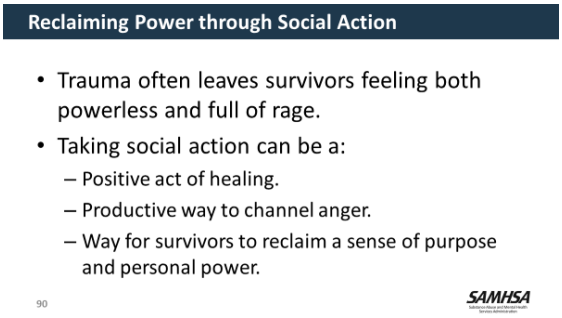
TALKING POINTS:

- Trauma has its roots in a society that allows abuses of power on both institutional and personal levels, and tolerates wide-spread violence and inequality.
- When we realize that the problem is bigger than ourselves, we can find strength in building community with others who want change.

Reference:

- Tedeschi, R. G., Park, C. L., & Calhoun, L. G. (Eds.). (1998). *Posttraumatic growth: Positive changes in the aftermath of crisis*. Routledge.

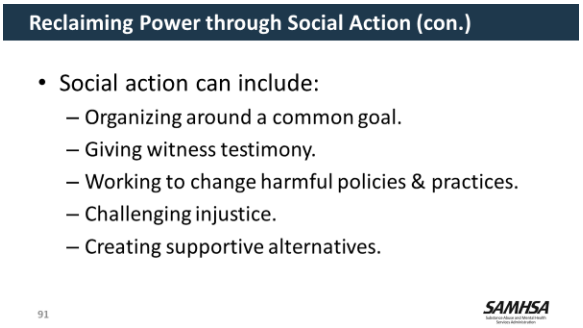
SLIDE 81: RECLAIMING POWER THROUGH SOCIAL ACTION



TALKING POINTS:

- The key point is that taking social action not only gives us a constructive way to channel our rage, but also helps build community connections as we work for social change.
- Survivors don't need to wait until they're "recovered" to take social action; the activity itself can be part of the healing process.

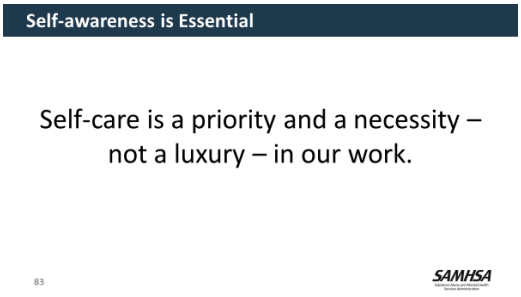
SLIDE 82: RECLAIMING POWER THROUGH SOCIAL ACTION (CON.)



TRAINERS' NOTE:

- *Give locally or personally meaningful examples of different times of social action activities (e.g., advocating against discriminatory laws or policies; speaking out in public forums about the impact of trauma and the need for trauma-informed practices; organizing community gardens or childcare collectives).*

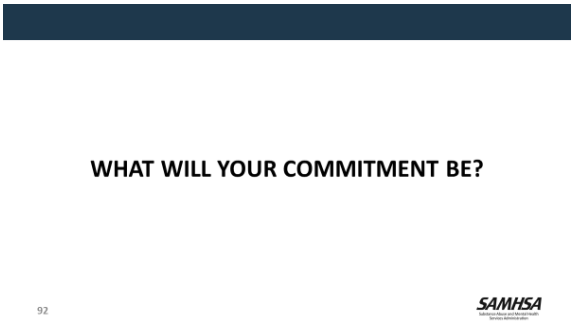
SLIDE 83: SELF-AWARENESS IS ESSENTIAL



TALKING POINTS

- Just as we started the day, it's important to end with a reminder that having a toolbox of self-awareness and self-care strategies is vital to our work in peer support.
- It's not just about self-care as in things we do for ourselves, like take a bath or go for a walk.
- We may need other people as part of our self-care strategy toolbox.
- Who can you talk to about your challenges and successes as a peer supporter? Who are your supports?

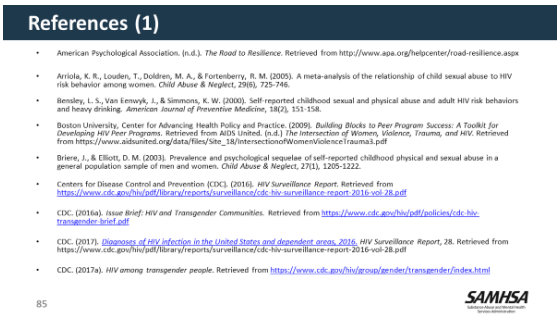
SLIDE 84: WHAT WILL YOUR COMMITMENT BE?

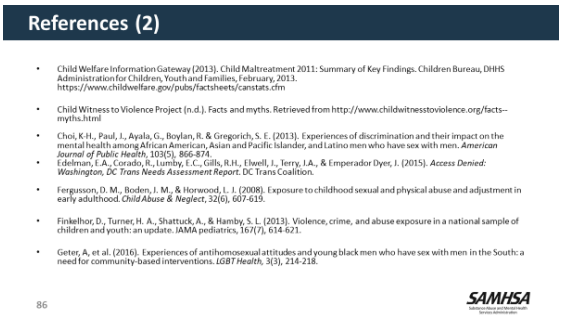


TRAINERS' NOTE:

- *Leave people with the question of what commitment they will make to take social action.*
- *How will they keep this work going?*

SLIDES 85-88: REFERENCES





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SLIDE 89: END SLIDE

Thank You

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