Trauma-Informed Approach: Improving Care for People Living with HIV Curriculum Trainer’s Manual
Acknowledgments

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SAMHSA’s Trauma-Informed Approach: Improving Care for People Living with HIV

WHO IS THIS TRAINING FOR?
This training curriculum was developed to serve as an introduction to trauma and trauma-informed approaches, with specific information about how to improve care and supports for people living with HIV. No prior knowledge about trauma is necessary. The training is intended for a wide range of potential audiences, including direct service providers, supervisors and administrators, advocates, service recipients, HIV navigators and mentors, and interested community members. Mixed audiences, with staff from different agencies, roles, or service systems, often work well. Including service recipients or family members along with staff can be especially effective—putting information about trauma directly in the hands of those most affected is empowering, and joint training creates a spirit of collaboration. In addition, the interactions that occur between trainees can lead to the development of new relationships and ultimately to more supportive and healing environments.

This training forms the basis for more advanced work in developing trauma-informed environments and practices. It should be completed before taking more specialized training.

THE TRAINING TEAM
This curriculum is intended to be taught by a team of at least two Instructors, preferably one of whom is living with HIV. Including a person with lived experience on the training team is a powerful way of modeling collaboration and empowerment. It can also be used to illustrate how people in different roles may experience the same events and circumstances differently. The training team should spend time getting to know each other before training together. It is helpful to discuss specifics about what role each person will play and to identify which sections and discussions each person will lead.

One trainer should have experience working in a setting that offers services or supports for people living with HIV. When possible, at least one trainer should have (and be willing to share) personal experience with trauma, HIV, and emotional healing in a situation that will resonate with the audience. People learn best from their peers, and there is no substitute for hands-on experience in making a training program relevant. When possible, try to match the person with lived experience to the audience so the words and experience will resonate with attendees, such as having a gay man who is living with HIV and has a trauma history present to staff in a health clinic that serves a large LGBTQIA-2 population. However, having experienced personal trauma is not enough to make a good trainer. It takes skill to go beyond simply telling one’s story to use personal experience as a teaching tool. If no one with lived experience is available, video clips included in the curriculum can be used to ensure that this perspective is represented.

TAILORING THE CURRICULUM TO YOUR AUDIENCE
While no training program can be “all things to all people,” this curriculum is designed to allow trainers to tailor content to meet the needs and interests of different audiences. To assist in this process, multiple slides have been provided for several core concepts.
We recommend that prior to the training you spend some time thinking about your audience—their backgrounds, levels of experience, work settings, and roles at work. Think about ways to tailor the basic information in the curriculum to audience members and try to share examples/stories that relate to the actual services and settings represented by your audience. Throughout this manual, some examples are given to spur your thinking, but trainers are encouraged to offer examples from their own personal and work experiences. Also, think about examples that are relevant to the service setting where the training takes place; for instance, examples about trauma-informed changes in residential youth settings may be interesting, but they will not have much relevance to staff working with an adult outpatient population.

Always keep the audience and their work roles in mind when coming up with examples of effective trauma-informed program changes; this way participants will be more motivated to think creatively about organizational changes they can make and individual things they can do differently within their work. When possible, before the training, talk with the organization’s leaders to identify what they are already doing that is trauma-informed and offer those examples as a starting point for audience members to think about additional changes that can be made.

At a minimum, select the specific PowerPoint slides, exercises, and video clips that will be most relevant to the audience’s work and experience. Tailoring the program in advance will eliminate the need to skip over irrelevant slides during the training.

We encourage trainers to use the PowerPoint slides as a flexible framework to be modified as you go. Good trainers draw heavily on their own wisdom, stay closely tuned to the audience, and provide examples “on the fly” based on their own experience.

**PREPARATION FOR TRAINING**

Before presenting this training program for the first time, it is essential that you become thoroughly familiar with all of the materials, including the Instructor’s Guidance, the PowerPoint slides and notes, and video clips (if used). It is important that you understand trauma, its prevalence and particular impacts on people living with HIV, and trauma-informed practices before you present this information to an audience.

One of the primary messages of training about trauma-related topics is that trauma can impact us in strong and enduring ways. So in addition to having robust training skills, it is important that you have both a solid knowledge of trauma-related topics and that you have self-awareness about trauma’s impact on your own mind, body, and spirit. During training, both trainers and participants may become emotionally affected by the material, so it is helpful to train in teams of two, both 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 reduce or mitigate the negative impact of trauma during training.

**A NOTE ABOUT LANGUAGE**

In keeping with the values and principles of trauma-informed approaches, the authors of this curriculum deliberately avoided using clinical language to the extent possible. In recognition of
the understanding that trauma responses are natural human responses to extreme circumstances, not “illnesses,” the curriculum does not focus on diagnostic terms such as PTSD (post-traumatic stress disorder) or borderline personality disorder. In addition, the curriculum does not use terms such as “vicarious trauma” or “secondary trauma,” because the authors do not believe that there is a hierarchy of traumatic experiences. The focus is on using everyday language to talk about people’s experiences.

Terms

**HIV/AIDS:** The terms “HIV” and “living with HIV” are used, rather than “HIV/AIDS” or “HIV and AIDS.” The general consensus is that individuals living with HIV and AIDS use the term “living with HIV,” so that is the terminology used in the presentation. This is because HIV is a virus, and AIDS (acquired immunodeficiency syndrome) is a condition or syndrome caused by HIV. People can have HIV without developing AIDS, and many people with HIV live for years without developing AIDS.

**LGBT:** This presentation presents information about people who are lesbian, gay, bisexual, or transgender (LGBT). The terms people use to identify their sexual and gender orientation can differ based on people’s preferences, communities, race, etc. Terminology for the trans-population also varies, based on sex/gender being viewed as a spectrum. For example, trans-feminine isn’t interchangeable with trans women; the latter is more specific.

“Transgender people” includes all people who are not, or do not identify with, the biological sex assigned to them at birth. At least one in three people who are transgender do not call themselves either women or men, but rather “non-binary”—people who fall somewhere between male and female on the spectrum (National Center for Transgender Equality, 2015). People who are non-binary may still lean more toward masculine or feminine, included in the broader terms “trans masculine” or “trans feminine,” rather than the very specific terms “trans man” or “trans woman.”

When working with trans people seeking HIV and AIDS care, “transfeminine” is a broader term for any person who does not identify with sex assignment at birth (trans) and is feminine of center—more feminine than masculine. This might include people assigned male at birth (AMAB) who are trans women, but it also can include people assigned female at birth (AFAB) who are non-binary, intersex, or androgynous. Where the presentation specifies “trans women,” it refers specifically to those women assigned male at birth (AMAB) for whom rates of sexual violence are similar to or higher than those of other women and rates of new infections of HIV are similar to or higher than those of other AMAB people who have sex with men.

**Trauma:** Trauma-informed practices are based on the universal expectation that trauma has occurred. This is sometimes referred to in literature as “universal precautions.” Many trauma survivors have found this term to be offensive, as it implies they “have” something to be feared.

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1 Definitions are a combination of adapted language from UNAIDS Terminology Guidelines and input from expert reviewers.
or is contagious. However, "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.

**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,” 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 small group or dyad discussions
- **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.

**SELF-AWARENESS**

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 traumatic 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:

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• 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

• Identify, use and adapt your interpersonal skills to model trauma-informed practices for participants

ADULT AS LEARNERS
Adults learn differently than children and teens 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 be sure to 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 key 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.

TRAINING TIPS
Here are some things to consider before delivering this training for the first time.

1) Know the difference between "listening" and "learning.”
Listening is passive, which means that lecture is the least efficient, least effective form of learning. Listening alone requires very little engagement on the learner’s part. Therefore, don’t talk more than 10-15 minutes without doing something interactive that stimulates
discussion. Offer opportunities for audience interaction when possible, such as by asking questions, including role playing exercises, or breaking into small discussion groups. The level of interaction will need to be based on audience size, the time allotted for the course, and the skill level of the trainer, but even in large groups, trainers should encourage some forms of audience interaction to maintain interest and reinforce the concepts being taught.

2) *Emotions provide the information for building memories.*
Feelings are the tags that determine how important a particular experience is and whether the learner understands it as a memory worth saving. People remember what they feel far more than what they simply hear or see.

3) *Acknowledge the power of feelings.*
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. Do not tell them what they feel—ask them!

4) *Vary your training methods to address the wide variety of learning styles.*
The curriculum incorporates a number of learning techniques; use all of them. Remember to keep lecture to a minimum and allow the process to work.

5) *Use stories to engage people in learning.*
People don’t always remember statistics, but stories are powerful because they engage the participants’ emotions. Stories speak directly to the heart and the imagination, so people tend to pay more attention to them. You can connect with the group by strategically sharing personal experiences, one of the personal stories available on video as part of the curriculum, or stories you have heard from others that relate to the topic you are discussing. When you share something that others can relate to, you help develop a rapport with the group and engage their emotions, which support the formation of new memories.

6) *It is more important to ask good questions than to supply all the answers.*
Trainers often fail to ask enough questions. Instead, they present solutions, which can leave participants feeling frustrated and interfere with learning. After you ask questions, restate what you have learned from the responses and to ensure that you understood correctly. You can do this by simply restating two or three of the key points you heard from participants.

7) *Keep your training skills and your knowledge base of the subject matter sharp and up to date.*
Good presenters keep abreast of the newest training techniques and tools. You should improve upon your skills through reading on the topic, attending seminars and seeking coaching from other facilitators. It is equally important that you keep your knowledge of trauma-related topics up to date as well.

8) *Establish your credibility in a low-key way.*
Participants do not care about your degrees, how smart you are, or what you have accomplished. While it’s important to establish a baseline level of credibility, it is far more
important that you care about how smart they are, what they know (and will know, thanks to this learning experience) and what they have done. Your job is to know far more about them than they know about you.

At the beginning of the session, you can quietly establish your credibility in an understated way (i.e., “We’ve done this training for 10 other peer-run programs across the country”). As a trainer, you nearly always come with a certain amount of credibility, even if the participants have never heard of you. It may be is helpful to provide a brief statement—a couple of sentences—about the work and history of your organization to support understanding the passion behind why you do what you do.

9) **Have a quick start and a big finish.**
   Give participants the opportunity to do something active and interesting very early. Do not bog them down with a long introduction. The faster they are engaged, the better. Don't let the class fizzle out at the end. Try to end on a high note. Ask yourself, "What were the participants feeling when they left?"

10) **Don’t assume that just because you said it, they got it.**
    Good trainers know how to slip in repetition in a stealthy way, where the material is presented again, but from a different angle.

11) **Be passionate and participants will respond in kind.**
    Be honest, be authentic, and, especially, be passionate about your message. Your passion will keep them awake. Your passion will be infectious, and it will provide the emotional hook to help people remember the content.

12) **Don’t think of yourself as the expert.**
    It's not about what you do or about what you know; it's about how participants feel about what they can do as a result of the learning experience you created. Rather than think of yourself as the expert, try thinking of yourself as "a person who creates learning experiences ... a person who helps others learn."

**PLANNING FOR THE TRAINING EVENT**

Each training is tailored to the specific audience—advance planning with the host organization should therefore, clarify the following issues:

- The organization’s goals for the training
- The extent of leadership’s commitment to trauma-informed practices
- Any issues or incidents that prompted the need for training or focusing on trauma
- Any previous staff training on trauma-related issues
- The length of training desired (i.e., half-day, full day; for residential facilities, whether training sessions are needed for all shifts)
- The estimated number of participants
• The size and set-up of the training facility (i.e., auditorium, large room with participants sitting at tables). It is important that the training environment is set up in a way that reinforces Trauma-Informed practices by considering individual vulnerability, safety, comfort, and ease of exit.

• Whether the host organization or the trainer will supply and set up:
  o Projector and screen
  o Laptop
  o Internet access
  o Speakers (needed if using video clips)
  o Handouts

LOGISTICS FOR THE DAY OF THE TRAINING
Plan to arrive at least 45 minutes 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 speakers for video, ensure that 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 are not cramped and have easy access to exists
INSTRUCTOR GUIDANCE

In the opening, Instructors introduce themselves very briefly and conduct a brief poll as a quick way to gauge who is in the room. Possible poll questions include asking about job titles, length of time in the agency, working with adults or children, etc. You can also ask about personal interest like who has pets, has seen a recent movie, etc., as an icebreaker.

Before concluding the introductory section, tell participants where the restrooms are, review the schedule for the day (preferably provided as a handout) including when breaks and lunch will be taken, and point out the emergency evacuation route.

SLIDE 2

Disclaimer

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SLIDE 3

Learning Objectives: Sections 1–5

- After this presentation, you will be able to:
  - Define trauma and the principles of a trauma-informed approach.
  - Recognize signs of trauma.
  - Describe the impact of trauma on the body and brain.
  - Understand the impacts of trauma on people living with HIV. HIV is human immunodeficiency virus.

TALKING POINTS

After this presentation, you will be able to:

- Define “trauma” and the principles of a “trauma-informed approach.”
- Recognize signs of trauma.
- Understand the particular effects of trauma on people living with HIV.
- Describe the impact of trauma on the brain.

SLIDE 4

TALKING POINTS

- Section one defines trauma and the three Es of trauma—events, experiences, and effects.
SLIDE 5

What is Trauma?

- Individual trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.
- Trauma can impact our relationships.

SLIDE 6

Social-Ecological Model of Trauma and Resilience

- SAMHSA’s definition of trauma focuses on the individual, but we also know that health is socially determined and occurs at all of these levels in our society.
- As we are relational beings, our individual health is impacted by the relationships we have throughout the course of our lives, within our families, the conditions of life in our community, and the larger social context in which we live.
- It is important to understand that not all people are equally impacted by trauma, and we will be talking about this more in looking at the impact of trauma on people living with HIV.

TALKING POINTS

- This framework for understanding trauma was developed by a working group of researchers, practitioners, trauma survivors, and family members convened by the Substance Abuse and Mental Health Administration, called SAMHSA. [pronounced SAM-su].
- It is important because it creates a framework for understanding the complex nature of trauma.
- It’s important to remember that trauma can rupture or impact our relationship with self or others.
• Communities of color, LGBTQI+, and Native and indigenous people have a much higher burden of trauma in this country and in this world.

SLIDE 7

**Things to Remember**

• Underlying question = “What happened to you?”
• What are called mental and substance use condition “symptoms” may be adaptations to traumatic events.
• Behaviors have meaning and purpose.
• Healing happens in relationships.

Video: Power of Empathy

**TALKING POINTS**

• The underlying question we should be asking is not “What’s wrong with you?,” but “What happened to you?”

• What are often called mental or substance use condition “symptoms” such as hypervigilance, dissociation, or panic attacks, may actually be adaptations to traumatic events.

• Behaviors have meaning and purpose. When you don’t understand someone’s behaviors, dig deeper and try to find the root of the behavior.

• As was already mentioned, trauma can impact or disrupt relationships with self and others.

• Therefore, healing happens in relationships, including relationships between health providers and people using services, and connections built through peer to peer support.

*Power of Empathy (Video - Brene Brown) available at [https://www.youtube.com/watch?v=1Evwgu369Jw](https://www.youtube.com/watch?v=1Evwgu369Jw)*
SLIDE 8

**Talking About Trauma**

- Experiences from our past influence our current behaviors.
- If, how, and when a person chooses to talk about life experiences is personal.
- Some may not label what happened to them as “trauma.”
- Be aware of the words you use and know that others’ words may be different.

**TALKING POINTS**

- Experiences from the past influence our current behaviors, including traumatic experiences.

- People need to choose for themselves if, when, and where they share their truths and experiences. People should never be forced or pressured to share painful memories.

- People have unique ways of understanding what happened to them. Some people may call an experience “trauma,” while someone else just calls it a “rough time,” or a “bad night.” Also, the same experience can mean different things to different people.

- We all have different perspectives about life experiences, and people use different language to explain their experiences. Don’t expect other people to use the same words you do to describe painful experiences.

- 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 if 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 person may not be able to describe what happened, understand what happened, or sometimes even remember what happened.

**INSTRUCTOR GUIDANCE**

It is particularly important to emphasize that many people experience multiple traumatic experiences over the lifespan. While the immediate focus might be on a recent event, the individual’s reaction to that event may be affected by earlier experiences.

Ask participants for an example describing how people they serve may experience multiple sources of trauma, or the following example can be offered:

*A veteran who has intrusive war-related memories who comes for support or treatment may have experienced neglect or abuse at home, lived in multiple foster care settings,*
and witnessed the impact of Hurricane Katrina while in the Reserves, all before being deployed and experiencing the military sexual trauma that brought her in for support or treatment.

A note about language: As discussed in the curriculum introduction, we deliberately are not using the terms vicarious trauma and secondary trauma.

**SLIDE 9**

**Group Reflection**

- How do you define trauma?
- What other words do you (or those with whom you work) use to describe experiences that could be called “traumatic?”

**TALKING POINTS**

Although we are talking about trauma, and just read a definition developed by SAMHSA, not everyone uses words such as “trauma.”

**INSTRUCTOR GUIDANCE**

Ask group to share their answers.

- *How do you define trauma?*
- *What other ways do you describe experiences like this?*

**SLIDE 10**

**The Three Es of Trauma**

**EVENTS**

Events/circumstances cause trauma.

**EXPERIENCE**

It differs from individual to individual.

**EFFECTS**

Effects can be broad and disguised as symptoms or behaviors.
TALKING POINTS

• The focus on events places the cause of trauma in the environment not in some defect of the individual. This is what underlies the basic credo of trauma-informed approaches: “It’s not what’s wrong with you, but what happened to you.”

• The focus on experience highlights the fact that not every child or adult will experience the same events as traumatic.

• The identification of a broad range of potential effects reminds us that our response must be holistic—it’s not enough to focus on symptoms or behaviors. Our goal is to support people as they strive to live satisfying lives.

SLIDE 11

Potential Traumatic Events—Brainstorm

<table>
<thead>
<tr>
<th>Abuse</th>
<th>Loss</th>
<th>Chronic Stressors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional</td>
<td>Death/farewell</td>
<td>Trauma/traumatic brain injury</td>
</tr>
<tr>
<td>Sexual</td>
<td>Abandonment and</td>
<td>Racism, homophobia</td>
</tr>
<tr>
<td>Physical</td>
<td>Neglect</td>
<td>Homophobia, immigration</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>Separation</td>
<td>Violence, medical procedure</td>
</tr>
<tr>
<td>Witnessing violence</td>
<td>Traumatic loss</td>
<td>Disability</td>
</tr>
<tr>
<td>Bullying/bullying</td>
<td>Accidents</td>
<td>Diversity</td>
</tr>
<tr>
<td>Institutional</td>
<td>Terrorism/war</td>
<td>Community/historical trauma</td>
</tr>
</tbody>
</table>

TALKING POINTS

• A wide range of events can potentially cause trauma. This slide lists some, but not all of them.

• Trauma can be caused by events that the individual doesn’t remember, such as events that occurred in early childhood.

• It can be caused by events that are well-intentioned and necessary, such as medical procedures.

• It can be caused by an event that didn’t happen to the person but to a group that he or she identifies closely with—as slavery, the Holocaust, or the genocide of Native American people.

• Over time, chronic stressors can accumulate to cause trauma. Living with HIV can be a chronic stressor. In fact, being diagnosed with a chronic, life-threatening illness is categorized as a traumatic stressor in the Diagnostic Statistical Manual.
• HIV-related discrimination also can be traumatic. This refers to negative beliefs, feelings, and attitudes toward people living with HIV, their families, and people who work with them. HIV-related discrimination, such as the unfair and cruel treatment of someone based on their real or perceived HIV status, can also be very traumatizing.

INSTRUCTOR GUIDANCE

Ask group to share their answers to these two questions

• What are the common traumatic events experienced by the people you work with?
• What would you add to this list?

SLIDE 12

Experience of Trauma

• Experience of trauma affected by:
  – How
  – When
  – Where
  – How often

TALKING POINTS

• The individual’s experience of trauma may be profoundly affected by how, when, how, where, and how often it occurs or occurred.

• The experience may also be affected by how well the person is supported by family, friends, and their community after the trauma. For example, is the person living with HIV supported by those they care about, or do they feel abandoned and isolated?

• Trauma can result from a single devastating event, called single-episode trauma (sometimes called acute trauma), or it can result from multiple traumatic events over time, such as repeated childhood and adult sexual abuse and sexual assault.

• Many individuals served in public systems, including people living with HIV, have complex trauma, which comes from experiencing multiple sources of trauma over a lifetime.

• Trauma can occur from hearing about, watching, or interacting with others who have had traumatic experiences.

• Organizations can sometimes cause harm through their procedures, even if unintentional.
For example, the routine practice of undressing for a medical exam can re-traumatize a person who has been physically or sexually abused.

OB/GYN exams can be very traumatic for women with sexual abuse histories, or for transgender men.

**SLIDE 13**

**Effect of Trauma**

The effect of trauma on an individual can be conceptualized as an understandable response to painful situations or conditions.

**TALKING POINTS**

- This is a definition of the effect of trauma.
- The effect is how the trauma alters a person’s future behavior, responses, health, relationships, psychological state, and so forth.
- We will talk more about this in the next few slides.

**SLIDE 14**

**Effect of Trauma (cont.)**

- Trauma can do the following:
  - Cause short- and long-term effects
  - Affect coping responses, learning, or developmental tasks
  - Affect a person’s behavior
  - Affect physiological responses and health, well-being, social relationships, and spiritual beliefs

**TALKING POINTS**

- Trauma can have both short- and long-term effects which may not be immediately recognized.
• Trauma can affect an individual’s coping responses or ability to engage in relationships, or it can interfere with mastery of developmental tasks.

• Trauma can impact a person’s behavior in ways that are hard for others to understand. For example, a person in a waiting room may become angry and agitated when told to wait if a provider is running late for an appointment. A person who gets angry when someone touches their arm or shoulder to get their attention may have been physically assaulted in the past and may have a startle response to being touched without warning. Behavior linked to trauma is most often a person’s way to protecting themselves against future harm.

• Trauma may also affect an individual’s physiological responses (we’ll talk more about this in the section on trauma’s effect on the brain and nervous system) and health, psychological well-being, social relationships, and spiritual beliefs.

SLIDE 15
Factors Increasing the Impact of Trauma

- Trauma occurred early in life
- Person experienced blaming or shaming
- Person was silenced or not believed
- Abuser was a trusted caregiver

TALKING POINTS

• The younger the age when trauma occurs, the more likely there will be lasting consequences. We will discuss why this is true—even when the individual has no memory of the trauma—when we briefly discuss how trauma affects the brain, or the neurobiology of trauma.

• Shame and humiliation are core features of the trauma experience for many people. These emotions can be devastating and impede healing. One of the most important messages you can give a trauma survivor is that no matter what happened, it wasn’t their fault in any way.

• Sometimes trauma survivors are intimidated by their abusers into not telling what happened. Other times, when they do try to talk about what happened to them, they are ignored or disbelieved. One of the most important things you can do for trauma survivors is to give them the chance to tell their stories. Healing starts when a person’s personal experience is heard and validated.
• The impact of trauma is magnified when the abuser is a trusted figure, such as a parent, relative, religious leader, coach, teacher, partner, or therapist. This kind of trauma is often called “betrayal trauma” because the sense of betrayal can be so profound.

**SLIDE 16**

**Trauma Linked to Health Challenges Over the Lifespan**

<table>
<thead>
<tr>
<th>Adverse Childhood Experiences</th>
<th>Biological Impacts and Health Risks</th>
<th>Long-term Health and Social Problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>The more types of adverse childhood experiences...</td>
<td>The greater the biological impact and health risks, and...</td>
<td>The more serious the life-long consequences to health and well-being.</td>
</tr>
</tbody>
</table>

**Talking Points**

• The Adverse Childhood Experience Study (ACE Study) was an extensive collaboration between Kaiser Permanente Insurance Company and the Center for Disease Control. Researchers surveyed 17,000+ people examining the impact of negative events in early childhood on people over their lifespan.

• The ACE Score gives a picture of the total amount of stress during childhood. Research has shown what is called a “dose-response” connection between the number of adverse childhood experiences (ACEs), or potentially traumatic experiences a person had before age 18, and health risks later in life. We’ll be talking more about these as we continue.

• The next three slides have the questions asked in the ACE study to determine childhood exposure to traumatic stressors. You may wish to make a note of any questions that stand out to you as you think about these events in your own life and in the lives of the people you serve.

**Reference:**

INSTRUCTOR GUIDANCE

These questions are from 1998, so the language and terms may feel outdated. If these questions were written today, they would be different. Please let people know this before you read the questions.

You can reword them as you read them. As an example, for question 3, the qualification of “at least 5 years older” is not a necessary age difference for touch to be traumatic.
TALKING POINTS

• For question 7, today it would likely be replaced with “Was there domestic violence in your home?” However, the term of "domestic violence" has a certain meaning among different populations.

• “Domestic violence” has traditionally been used to define as "violent or aggressive behavior within the home, typically involving the violent abuse of a spouse or partner. However, it can include "violent or aggressive behavior" experienced by any family member—parents, siblings, or other relatives, and friends living in the house. Also, domestic violence is now recognized to include emotional abuse, as well as physical.

SLIDE 20

**Childhood Experiences Affect Health/Social Outcomes**

<table>
<thead>
<tr>
<th>Behaviors</th>
<th>Health outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism and alcohol use</td>
<td>Depression</td>
</tr>
<tr>
<td>Substance use</td>
<td>Suicide attempts</td>
</tr>
<tr>
<td>Smoking</td>
<td>Fetal death</td>
</tr>
<tr>
<td>Early initiation of smoking</td>
<td>Sexually transmitted infections (STIs), including HIV</td>
</tr>
<tr>
<td>Early initiation of sexual activity</td>
<td>Health-related quality of life</td>
</tr>
<tr>
<td>Multiple sexual partners</td>
<td>Ischemic heart disease (IHD)</td>
</tr>
<tr>
<td>Reproductive outcomes:</td>
<td>Liver disease</td>
</tr>
<tr>
<td>Unintended pregnancies</td>
<td>Chronic obstructive pulmonary disease (COPD)</td>
</tr>
<tr>
<td>Adolescent pregnancy</td>
<td>Social outcomes:</td>
</tr>
<tr>
<td>Future violence:</td>
<td>Homelessness</td>
</tr>
<tr>
<td>Risk for intimate partner violence</td>
<td>Incarceration</td>
</tr>
</tbody>
</table>

Source: CDC, n.d

INSTRUCTOR GUIDANCE

• The ACE Study found that the more adversity a person experiences, the greater the risk of many health conditions, including HIV and sexually transmitted infections. Many health risks related to ACE scores come from previous trauma, not HIV, as many health conditions are linked to trauma, including gastrointestinal problems, diabetes, and heart disease (Fang, Chuang, & Lee, 2016).

• We understand many of the behaviors listed in the top left column can be understood as coping mechanisms, to soothe pain or to experience closeness and connection with others.

• The ones highlighted in blue are connected with behaviors that put people at risk for HIV.

• ACEs can impact:
  o Development of healthy sexuality.
  o Perceptions of power in sexual relationships.
  o The ability to negotiate safer sex practices.
  o Choice and number of sexual partners.
  o Underestimating risk in sexual relationships.
References:


SLIDE 21

**ACE Study Findings**

A *male* child with an ACE score of 6 has a 4,600% increase in likelihood of later becoming an IV drug user when compared to a male child with an ACE score of 0.

Might heroin be used for the relief of profound anguish dating back to childhood experiences? Might it be the best coping device that an individual can find?"

Felitti et al., 1998, www.acestudy.org

TALKING POINTS

- This slide emphasizes the point that drug use may be the best way of coping an individual has in the face of adverse childhood experiences.

- **SHOW VIDEO**: what is addiction by Dr. Gabor Mate, author of *In the Realm of the Hungry Ghosts: Close Encounters with Addiction*.
  
  o Main takeaway is “Addictions begin with pain and end with pain.”
  
  o The way that we can begin to work through the pain is in the context of a safe relationship.

Reference:

This is a very difficult slide, but it shows that ACEs can impact just not the quality of a person’s health, but actually can reduce their life expectancy. We see this cumulative impact of adversity in childhood and adulthood on the lives of people living with HIV, which we will discuss later in this training.

- Resilience is defined as “The ability of an individual, family, or community to cope with adversity and trauma and adapt to challenges or change.”
  — The Substance Abuse and Mental Health Services Administration (SAMHSA)
- Resilience is promoted in part by supportive relationships and social connectedness, as well as addressing sources of adversity.

Source: https://www.samhsa.gov/capt/tools-learning-resources/trauma-resilience-resources

INSTRUCTOR GUIDANCE

- When we talk about ACEs, the danger is that we or the people we serve will assume that a high ACE score is “destiny,” so why even try?
- But it’s important to understand that adversity is not destiny.
- There are resilience factors that can lessen the impact of ACEs 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.”
- And we also need to address the adverse conditions that people face in their lives, families, and in their communities—including violence and inequality.
Reference:


SLIDE 24

**Resilience Score (1–3)**

1. I believe that my mother loved me when I was little.
2. I believe that my father loved me when I was little.
3. When I was little, other people helped my mother and father take care of me and they seemed to love me.

**INSTRUCTOR GUIDANCE**

- There are 14 questions in this Resilience Questionnaire. You do not need to read all these questions, just touch one or two in each of the slides.

**TALKING POINTS**

The ACE questionnaire does not take into account any protective factors that reduce the negative health and social outcomes we have discussed so far.

- To try to balance the focus on negative childhood experiences in the ACE questionnaire, practitioners encourage conversations about strengths and resilience.
- This questionnaire was developed by the early childhood service providers, pediatricians, psychologists, and health advocates of Southern Kennebec Healthy Start, Augusta, Maine, in 2006, and updated in February 2013.
- Two psychologists in the group, Mark Rains and Kate McClinn, came up with the 14 statements with editing suggestions by the other members of the group.
- Each question is ranked on a scale from Definitely True to Definitely Not True.
- The scoring system was modeled after the ACE Study questions.
- The content of the questions was based on a number of research studies from the literature over the past 40 years, including that of Emmy Werner and others. Its purpose is limited to education.
- Note how many of the protective factors involve supportive relationships with family or other adults in the community.
References:


**SLIDE 25**

**Resilience Score (4–6)**

4. I’ve heard that when I was an infant, someone in my family enjoyed playing with me, and I enjoyed it, too.

5. When I was a child, there were relatives in my family who made me feel better if I was sad or worried.

6. When I was a child, neighbors or my friends’ parents seemed to like me.

**SLIDE 26**

**Resilience Score (7–9)**

7. When I was a child, teachers, coaches, youth leaders or ministers were there to help me.

8. Someone in my family cared about how I was doing in school.

9. My family, neighbors and friends talked often about making our lives better.

**SLIDE 27**

**Resilience Score (10–14)**

10. We had rules in our house and were expected to keep them.

11. When I felt really bad, I could almost always find someone I trusted to talk to.

12. As a youth, people noticed that I was capable and could get things done.

13. I was independent and a go-getter.

14. I believed that life is what you make it.
TALKING POINTS

- Our past experiences affect our current behaviors, reactions, views, relationships, risks of future high-risk behaviors and health issues, and perspective of the world. This includes traumatic experiences, and there are both short and long-term effects of trauma on the body and the mind. The ACE Study found that the adverse outcomes experienced during childhood increase the risk of many health conditions, including substance use and HIV.

- Once you understand that signs and symptoms of trauma are a reflection of past occurrences, the first step is to prioritize healing from trauma as the focus of care, and this can be done by shifting from a focus on what is wrong with people to what happened to them, rather than focusing on diagnoses or labels.

- But it’s important to look at not only “what happened” to people, but also how they have survived, including strengths and resilience factors.
TALKING POINTS

• All experiences change the brain, yet not all experiences have equal impact on the brain.

• Because the brain is organizing at such an explosive rate in the first years of life, experiences during this period have more potential to influence the brain—in positive and negative ways.

• Early experiences, especially traumatic ones, shape human development. We develop ways to cope, survive, and defend ourselves against deep and enduring wounds.

TALKING POINTS

• The brain has a bottom-up organization.

• The bottom regions, such as the brainstem and midbrain, control the most simple functions. These include respiration, heart rate, and blood pressure regulation.

• The top areas of the brain, such as the limbic and cortex, control more complex functions. These include thinking, problem solving, and regulating emotions.
• At birth, the human brain is undeveloped. Not all of the brain's areas are organized and fully functional.

• During childhood the brain matures and the whole set of brain-related capabilities develop in sequence. For example, we crawl before we walk, we babble before we talk.

• The development of the brain during infancy and childhood follows the bottom-up structure.

• The most regulatory, bottom regions of the brain develop first; followed, in sequence, by adjacent but higher, more complex regions.

• The process of sequential development of the brain is guided by experience.

Note: This information is from the work of Bruce D. Perry, M.D., Ph.D., an internationally recognized authority on brain development and children in crisis (www.childtrauma.org).

SLIDE 32

Bottom Up Reaction to Fear

Video: Toxic Stress Derails Development

TALKING POINTS

(Video is at https://www.youtube.com/watch?v=rVwFkcOZHJw&feature=youtu.be)

• The “fire alarm” of the brain is located in the amygdala. It sounds the alarm about a threat and activates the fear response.

• The frontal lobes of the cortex – at the top or the thinking part of the brain – shut down to make sure the person is focusing completely on survival. That’s why it is so hard to think when you are in a crisis!

• At the same time, the ability to perceive new stimuli decreases, and the focus is on information and processes to ensure survival.

• The area of the brain responsible for speech, called “Broca’s area” shuts down. So when people talk about “speechless terror” or “being scared speechless” they are not being metaphorical, they are describing a real response of the brain.
• This has important implications for how each of us responds to crisis situations or to people who are responding to the present through the lenses of their past.

• In our work, we often approach people in distress, asking them to tell us what is wrong, to stop and think, or tell us how we can help. Access to the thinking resources of the brain may not be possible in these moments.

• If we ask people in this state to “tell us what’s going on,” they may really not be able to do it! In that moment, they may actually not have the words.

• When a person remembers a traumatic event, the fear response can be activated, just like it was when the event occurred. From the brain’s perspective, it’s like the threat is actually happening again.

**SLIDE 33**

**Flight, Fight, or Freeze: The Trauma Response**

- The brain signals the body to respond to a perceived threat, and the body prepares.
- Ordinarily, when the threat is gone, the body returns to “baseline.”
- But if an ongoing threat is perceived, the body doesn’t return to baseline, remains prepared for threat, resulting in a “trauma response.”
- The switch is stuck in the “on” position.

**TALKING POINTS**

• Consider this quote from Nadine Burke Harris, pediatrician, from her viral TED Talk, “How Childhood Trauma Affects Health Across a Lifetime:"

  “Imagine you’re walking in the forest, and you see a bear. Immediately, your hypothalamus sends a signal to your pituitary, which sends a signal to your adrenal gland that says, release stress hormones, adrenaline, cortisol. And so your heart starts to pound. Your pupils dilate. Your airways open up. And you are ready to either fight that bear or run from the bear. And that is wonderful if you’re in a forest, and there’s a bear. But the problem is what happens when the bear comes home every night. And this system is activated over and over and over again. And it goes from being adaptive or lifesaving to maladaptive or health-damaging. Children are especially sensitive to this repeated stress activation because their brains and bodies are just developing. High doses of adversity not only affect brain structure and function. They affect the developing immune system, developing hormonal systems and even the way our DNA is read and transcribed.”

• 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.
• The alarm is sounded and 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 releasing adrenalin, pupils dilate, breathing changes, etc.

• When the threat is gone the body typically returns to baseline.

• But if a person is continually and repeatedly under threat, 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.

• Ask: How might you see these responses occur in a waiting room or during an office visit?

SLIDE 34

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:


SLIDE 35

The Brain Can Change

Our brains are “neuroplastic,” meaning that they can change and adapt based on our environments and experiences (Campbell, 2018).

TALKING POINTS

- Again, it’s important to note that early adversity is not destiny. Although we used to think that 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, 2018).

- 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:

SLIDE 36
Section 2: Summary of Key Points

• Trauma affects brain development and changes behavior and responses to life experiences.
• Trauma triggers, or reminders, can result in fight, flight, or freeze responses.
• Many “symptoms” and “behaviors” are adaptations to traumatic experiences.
• People can learn to better regulate their nervous systems with the right strategies and support.

TALKING POINTS
• Trauma impacts brain development and changes behavior and responses to life experiences.

• Trauma triggers, or reminders, can result in fight, flight, or freeze responses.

• When we take a trauma-informed approach, we recognize “symptoms” and “problem behaviors” as adaptations to trauma.

• People can learn to better regulate their nervous systems in the face of challenges and stress.

SLIDE 37
Section 3: Trauma & HIV
TALKING POINTS

- This section describes the relationship of trauma to HIV.

SLIDE 38

“Providers recognize that patients may have past trauma, but what few realize is how prevalent it is and how much it affects patients’ health.”

—Michael Mugavero, 2009

TALKING POINTS

- This quote is from a researcher with **Coping With HIV/AIDS in the Southeast (CHASE) Study**. The study is looking at the impact of people living with HIV in the South, speaks to the importance of providers understanding the impact of trauma on the lives of people living with HIV.

- In this section, we will look more closely at the intersections between trauma and health outcomes of people living with HIV.

Reference:


SLIDE 39

**Trauma and HIV: What’s the Connection?**

- People living with HIV experience disproportionately high rates of trauma throughout the life span.

- Traumatic experiences, including histories of childhood sexual and physical abuse, are far more common among people living with HIV than in the general U.S. population.

- People living with HIV are also disproportionately affected by adult trauma, including intimate partner violence (IPV).

- Lifetime trauma impacts both HIV-risk behavior and the ability of people living with HIV to engage in HIV care.
**TALKING POINTS**

- It's important to understand that 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 prevalence and impact of trauma on individuals who are most impacted by the HIV epidemic.

**Reference:**


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**SLIDE 40**

**Why We Must Focus on Trauma**

- The vast majority of women living with HIV (WLHIV) are dying not from HIV-related causes but from murder, suicide, addiction, and other causes associated with lifelong trauma (French et al., 2009).

- A 2018 California-wide study found that WLHIV were more than 25 times more likely to die from an overdose or a mental health condition related to substance use than the general population of women in the state (Hessol et al., 2018).

- The same study found that men living with HIV were nearly three times as likely to die by suicide than the general population of men in California.

- HIV (like many other health conditions) is a symptom of a far larger problem: widespread, unaddressed trauma.

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**INSTRUCTOR GUIDANCE**

*Trainers might find it helpful to review this 20-minute video presentation prior to training on this curricula:*


**TALKING POINTS**

- 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).
References:


SLIDE 41

**Impacts of Trauma on Health: Structural Violence**

INSTRUCTOR GUIDANCE

- 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 people with HIV.

• Structural violence can encompass things in these circles such as:
  o Institutional racism;
  o Homophobia, transphobia, and other stigmatizing social norms;
  o Criminalization of sex work, substance use, and HIV status;
  o Discrimination in housing, work, education, or health care; and
  o 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 impacts 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 in your service setting.

References:


TALKING POINTS

• This slide shows the populations with the highest rates of HIV diagnoses in 2016. The chart does not distinguish transgender or intersex populations. Data is limited for transgender/intersex populations.

• In the next slides we will talk about how trauma intersects with health outcomes and points the way to focus on trauma-informed support for various populations.

• It is vital to discuss rates of HIV and trauma among the transgender population, as rates among this population are epidemic and they have less access to resources and medical care.

• We know HIV disproportionately affects trans people, but studies that actually collect trans-specific data related to HIV are very rare, partly because transgender women are still counted as men, or men who have sex with men, in the vast majority of HIV testing and treatment programs.

• However, organizations such as the Center of Excellence for Transgender Health, the Human Rights Campaign, and the CDC estimate that as much as 25% of trans women are living with HIV. In addition, the CDC reports that from 2009 to 2014, 2,351 transgender people were diagnosed with HIV in the United States, and 84 percent of those were transgender women (CDC, 2017). About half of those trans women are from the south.

• Also among the 3.3 million HIV testing events reported to CDC in 2013, the percentage of transgender people who received a new HIV diagnosis was more than three times the national average (CDC, 2017).

• Another study of HIV diagnoses among transgender people showed that from 2009 to 2014, 51 percent of those diagnosed were Black/African American trans women, and 58 percent were Black/African American trans men (Lark, et al., 2016; CDC, 2017).

References:


• Lark, H., Babu, A. S., Wiewel, E. W., Opoku, J., & Crepaz, N. (2016). Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV

SLIDE 43

**Men, HIV, and Lifetime Trauma**

- Up to 25% to 65% of HIV-positive men who have sex with men (MSM) report experiencing childhood sexual abuse (CSA) (Schafer, 2013; Welles, 2009).
- Trauma experiences are not limited to CSA but also homelessness, physical abuse/violence, and incarceration (Wilson, 2013).
- Gay and same-gender-loving men living with HIV are significantly affected by intimate partner violence (IPV).
- HIV-positive MSM face chronic stress from stigma relating to their HIV status as well as their sexual orientation.

*Trans-specific risks will be noted in the next few slides.*

**TALKING POINTS**

- Although few studies have centered on men who have sex with men who are living with HIV, the few studies that do exist show an increased risk for those with histories of childhood sexual abuse.
- There is also limited research on the prevalence of IPV among HIV-infected minority men and non-heterosexual populations.
- Among HIV-positive MSM, a history of sexual abuse has been linked to HIV sexual transmission behavior.
- HIV-positive MSM face chronic stress from stigma relating to their HIV status as well as their sexual orientation.
- Sexual minority stress among MSM stems from discrimination, marginalization, and violence, which can lead to disruptions in coping mechanisms, emotional regulation, interpersonal attachments, and cognitive functioning.
- This stress can also precipitate everyday expectations of rejection, distress related to concealing sexual identity, and internalized homophobia.
- Discrimination-based interpersonal trauma, including bias associated with being Black, HIV-positive, or gay, has been linked with HIV sexual transmission behaviors.
- Sexual minority stress among HIV-positive MSM can ultimately result in decreased self-care, decreased engagement in primary care, and poor HIV-related outcomes.
References:


Women, HIV, and Lifetime Trauma

- Rates of childhood sexual abuse and childhood physical abuse: 39% and 42%, respectively, among women living with HIV, more than twice the national rates (Machtiger et al., 2012).
- Women who experienced childhood sexual abuse have a reported seven-fold increase in HIV risk behaviors (Bensley, Van Eenwyk, & Simmons, 2000; Senn, Carey, & Varable, 2008).
- Trans women experience high rates of physical (57%) and sexual assault (47%) (Edelman et al., 2015):
  - 57% of trans feminine individuals had been physically assaulted compared to 17% of trans masculine individuals.
  - 47% of trans feminine individuals had been sexually assaulted compared to 14% of trans masculine individuals.
- Childhood sexual abuse is associated with a higher risk for sexual risk behaviors in women, such as unprotected sexual intercourse, sex with multiple partners, and sex trading (i.e., sex for money, drugs, shelter) (Arriola et al., 2005).
- Childhood sexual abuse in women also has potential lifelong psychological effects that are associated with a high risk of HIV acquisition and poor adherence to medical care following a diagnosis of HIV (Maniglio, 2009).

References:


**SLIDE 45**

<table>
<thead>
<tr>
<th>Transgender Population, HIV, and Trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transgender people experience very high rates of violence. According to one study (Edelman et al., 2015), 74% had been verbally assaulted, 42% had been physically assaulted, and 35% had been sexually assaulted.</td>
</tr>
<tr>
<td>Transgender women are disproportionately the victims of hate violence (National Coalition of Anti-Violence Programs).</td>
</tr>
<tr>
<td>Lack of trust in medical professionals and mistreatment in healthcare settings results in transgender women's reduced engagement in care and reduced confidence in their ability to manage HIV (Volpe &amp; Cahill, 2018).</td>
</tr>
</tbody>
</table>

**SAMHSA**
ALKING POINTS

• Experiences of assault are more common among transgender people of color compared to White transgender individuals, and more common among trans feminine individuals compared to those who are trans masculine.

References:


SLIDE 46

Lifetime Trauma and HIV Risk

Lifetime trauma can affect:

— The development of healthy sexuality.
— Perceptions of power in sexual relationships.
— The ability to negotiate safer sex practices.
— One’s choice and number of sexual partners.
— Underestimating risk in sexual relationships.

TALKING POINTS

• Multiple studies have found strong associations between trauma history, substance use, and HIV sexual transmission behaviors.

• The relationships between ACEs, substance use, and sexual behavior are complex. However, this can be a sensitive subject and it’s VERY important to emphasize that we are not seeking to shame or blame individuals when talking about ACEs and high-risk sexual behavior. People are seeking closeness, connection, and intimacy in their lives. But growing up in violent, emotionally abusive, or dangerous households may cause people to underestimate risk in sexual relationships.
References:


SLIDE 47

**Trauma and Risk Behaviors Among People Living with HIV**

- Trauma is associated with a higher incidence of HIV transmission among both people living with HIV and HIV-negative people (Brezing & Freudreich, 2015).
- Among HIV-positive men having sex with men, unprotected sex with casual partners is associated with adverse childhood experiences, especially sexual abuse (Kamen et al., 2013).

References:


SLIDE 48

**How Trauma Affects Engagement in HIV Care**

Studies indicate that people living with HIV with past or recent trauma:

- Take longer to be linked with care after being diagnosed.
- Are less likely to stay engaged in care.
- Are less likely to adhere to antiretroviral therapy (ART).

**Talking Points**

- Past trauma impacts engagement in care. (Soto et al., 2013; Lesserman et al., 2008; Lesserman et al., 2005).
References:


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**SLIDE 49**

**Trauma and Antiretroviral Medications**

- Taking antiretroviral therapy (ART) differently than prescribed is correlated with frequent childhood trauma, childhood sexual abuse, depression, and PTSD (Whetten et al., 2013; Meade et al., 2009).

- HIV-positive women with recent trauma are four times more likely to experience ART failure (Machtinger et al., 2012b).

- Sexual trauma is associated with greater likelihood of ART being unable to control HIV infection; a term for this is "treatment failure" (Machtinger et al., 2012b).

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**References:**


Numerous studies have demonstrated the adverse impact of trauma upon the health outcomes of people living with HIV.

Recent or lifetime trauma is associated with the following:

- HIV risk factors/HIV incidence
- Faster disease progression
- More hospitalizations
- Almost twice the rate of death

Jane Leserman, PhD, a psychiatrist at the University of North Carolina Chapel Hill, investigated the consequences of stress and trauma in a group of 490 men and women with HIV in the South.

The number of people reporting past trauma was high—33% had been sexually abused, 38% had been physically abused, and 18% reported both types of abuse.

Trauma significantly predicted risk of death from HIV or other causes.

Reference:

TALKING POINTS

• Awareness is key. The more we can bring unconscious thoughts, feelings, and assumptions into the light, and look at every connection we make through a trauma and resilience lens, the more we can “be that person” to inspire a sense of empowerment in everyone we work with.

• Being treated in a trauma-informed setting by trauma-informed providers is key in helping people living with HIV achieve better health and mental well-being.

• The next section will help you understand how to implement a trauma-informed approach when working with clients living with HIV.

TALKING POINTS

• This section provided information on the prevalence of violence in the general population, and among specific populations.
• Trauma affects physical and mental health and general well-being. It can lead to high-risk behaviors, mental health issues, and the ability to engage in HIV treatment, as well as death.

• Healing is possible. The more providers can bring unconscious thoughts, feelings, and assumptions into the light, and look at every connection we make through a trauma and resilience lens, the more we can “be that person” to inspire a sense of empowerment in everyone we work with.

SLIDE 53

SLIDE 54

The Four Rs

A trauma-informed program, organization, or system:

• Realizes
  — Realizes widespread impact of trauma and understands potential paths for recovery

• Recognizes
  — Recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system

• Responds
  — Responds by fully integrating knowledge about trauma into policies, procedures, and practices

• Resists
  — Seeks to actively resist re-traumatization

TALKING POINTS

• The four Rs highlight basic aspects of culture change that an organization will demonstrate as it becomes trauma-informed.

• The dour Rs reflect that it is not enough to simply know about trauma.

• To be trauma-informed, people must be able to identify trauma when they see it, and they must know how to respond in a way that doesn’t unintentionally re-traumatize people.

• Trauma-informed approaches can be implemented anywhere, by anyone. Everyone in the organization has a role to play in becoming trauma-informed.
SLIDE 55

SAMHSA’s Six Key Principles

- Six principles that guide a trauma-informed change process
- Developed by national experts, including trauma survivors
- Goal: Establish common language/framework
- Values-based approach
- A way of being

TALKING POINTS

- SAMHSA’s principles for trauma-informed approaches emerged from a year-long process involving trauma survivors, family members, practitioners, researchers and policymakers.

- During a public comment period, thousands of individuals wrote in with feedback on the definitions and overall approach.

- The goal was to develop a common language and framework. As more agencies and organizations work to become trauma-informed—and as more and more claim to BE trauma-informed—there needs to be some standard way to define and assess consistency with the approach.

- The principles are value-based. Unlike “manualized” models for specific treatment interventions, these principles can be applied in a wide variety of settings, in many different ways, using whatever resources are available.

- Implementing a trauma-informed approach requires constant attention and caring; it’s not about learning a certain technique or checking things off a checklist. Think about something as basic as respect or compassion. Can you do it once, implement a policy, and then check it off as “done”? Trauma-informed approaches are about a way of being, not a specific set of actions or implementation steps.

- A trauma-informed approach reflects a fundamental shift in the culture of an entire organization, not one particular treatment modality or program.

- A trauma-informed approach is a way of being and a way of approaching all your interactions with those with whom you serve.
SLIDE 56

Six Key Principles of a Trauma-informed Approach

- SAMHSA's six principles are:
  1. Safety
  2. Trustworthiness and transparency
  3. Peer support
  4. Collaboration and mutuality
  5. Empowerment, voice, and choice
  6. Cultural, historical, and gender issues

TALKING POINTS

- We will discuss each principle in detail over the next section.

SLIDE 57

Principle 1: Safety

Throughout the organization, staff and the people they serve, whether children or adults, should feel physically and psychologically safe.

TALKING POINTS

- The principle of safety refers to physical and psychological safety that is felt throughout the organization, among staff, and among the people served.

- Those who are coming in for HIV testing, psychological support, medical treatment, or peer support may feel vulnerable and nervous. They may be coming in for the first time after diagnosis; they may be seeing new providers or be joining a support group for the first time. They deserve to feel welcomed, safe, and comfortable when they arrive at and receive services at your facility.

- Safety includes many physical and psychological aspects. These are just a few elements that can make a setting feel safe and healing, or unsafe:
  - The outside and inside of a building can either be welcoming, or non-welcoming. Welcoming environments feel supportive, comfortable, safe, and respectful. They are conducive to healing. Non-welcoming environments feel uncomfortable, disrespectful, and unsafe. They can lead to anxiety, stress, and mistrust.
Think about your facility. Is the furniture comfortable and arranged to give people space and a feeling of privacy? Are there magazines in the waiting area that would be of interest to the populations you serve? Is the art work representative of the people getting services? Are the front desk staff friendly and helpful? Those all help make the space feel safe.

In contrast, spaces with worn out or uncomfortable furniture, signs stating “no weapons allowed,” rude front desk staff, and magazines and art work that doesn’t reflect the people being served make a place feel less safe, psychologically less welcoming, and often displays a lack of respect or care for those being served.

Is your building located in a safe area of town? If the area is in a less-safe part of town, are there escorts to walk people to the parking lot at night? Is the parking lot well-lit? Is the building easily accessible from public transportation? Would people who are LGBT be in danger of harassment or violence if they walk alone to your facility?

INSTRUCTOR GUIDANCE (Video is at: https://youtu.be/73mPbcOZ8Cg)

Please show the video and ask participants the following questions:

How can we address the concerns of Brian regarding the environment?

- What about when someone walks into a waiting room with no one there to greet them?
- Can we consider involving peer support in our waiting rooms to greet people and to offer them water and orient them?

Margot’s story is a reminder that, especially for long-term survivors, there may have been many negative prior interactions with healthcare providers that put them on guard, expecting further mistreatment. Rod also spoke of being on guard and expecting harm.

Many of the people we interviewed for these videos made mention of the importance of eye contact. Although we have to be culturally sensitive, keeping in mind that not all people prefer to
make eye contact for various reasons, it highlights the importance of making eye contact as a way to communicate care and respect.

Rod talks about safety as the “unfamiliar feeling of being accepted.”

- How can we foster that feeling in the people that we work with?
- How can we communicate the message that people will be “all right?”

Debbie spoke about the importance of agencies “getting it right?”

- What do you think she meant by that?
- Do you think it was connected to Rod’s “unfamiliar feeling of being accepted.”
- What are the ways that agencies can help people living with HIV to feel safe and accepted? (Sample answers: make eye contact, greet people warmly, offer a bottle or cup of water.)

SLIDE 59

**Who Defines Safety?**

- For people who use services:
  - “Safety” generally means maximizing control over their own lives.
- For providers:
  - “Safety” generally means maximizing control over the service environment and minimizing risk.

**TALKING POINTS**

- Many of these principles—like safety—sound so simple and obvious that you might wonder why it needs to be highlighted. Of course we want everyone to be safe!

- But if we go below the surface, a more complicated reality emerges.
  
  o How do you feel when you enter into a service environment with plexi-glass windows and only a small slot through which to push paperwork and money? Things that are done to keep the overall environment “safe” may send a message to clients that this is not a safe environment or that staff are afraid of the clients.

  o Will a person who identifies as transgender or non-binary feel safe and welcomed if they have to answer gender-related questions on an intakes form, such as a check box for “male” or “female”? People are often misgendered,
which means that people have their transition or gender questioned. In a service setting, that could cause the person to feel uncomfortable.

• So what can you do in a situation like this? First, recognize that safety may look different depending on your role and situation—or your personal history. The best thing you can do is to ask each individual what makes them feel safe and unsafe.

• This may mean rethinking policies and practices to attend to what both clients and staff mean by safety.

• The next slide shows the way signs at a facility can promote safety and welcome, or the opposite.

SLIDE 60

“Signs” of Safety and Respect

TALKING POINTS

• One the left is an example of a sign that isn’t very respectful or welcoming to the community members coming here to seek services. It’s a time when they may need great support, and instead they encounter a cold, non-welcoming sign the moment they approach the building.

• On the right is a sign that is welcoming and helps people of all races, ethnicities, sexual orientations, and genders feel safe and welcomed.

• Even just one sign can influence the tone for a person’s entire experience.
Interpersonal Communication

• Interpersonal interactions should promote a sense of safety.

• What are some ways you ensure interactions that promote a sense of safety?

TALKING POINTS

• Interpersonal interactions should also promote a sense of safety. Some ways to do this include the following:

  o Ensure front-desk staff are trained to be welcoming and to notice signs of distress and anxiety in consumers.

  o Let people list their gender on in-take forms, rather than just offering two choices: “male” or “female.”

  o Ask for people’s preferred gender pronoun, and ensure staff respect that choice.

  o Welcome people with a smile and a hello, even if they have to wait in line. Don’t make people wait to feel their presence is acknowledged and welcomed.

  o If people have to wait a long time for services, ask if there is something you can do to help them feel comfortable, such as offering a bottle of water, pointing out the restrooms, showing them the magazine selection, giving them the wifi password, and apologizing for the wait and keeping them informed of wait time.

  o Ask: What are some ways you ensure interactions with consumers promote a feeling of safety?
INSTRUCTOR GUIDANCE

- *Ask group for answers to question on the slide.*

TALKING POINTS

- Safety is a surprisingly volatile issue for staff as well as people served.
- Often, physical safety is a concern, especially for people who work at night and have to walk into dark parking lots or who work in rough neighborhoods.
- Incidents of workplace violence can have a ripple effect far beyond the specific circumstances.
- Staff may fear that their jobs are in jeopardy due to budget cutbacks, or they may be terrorized by workplace bullying.
- While these issues cannot be resolved in this workshop, getting people to identify their safety concerns is an important first step.
TALKING POINTS
Principle 2 focuses on:

- Maximizing trustworthiness, making tasks clear, and maintaining appropriate boundaries.
- Organizational operations and decisions are conducted with transparency.
- Constantly building trust.

SLIDE 64

INSTRUCTOR GUIDANCE

Video is at https://youtu.be/-i3H3jxFk6M

Please show the video and ask participants the following questions:

Brian spoke in the video about how he felt that his doctor did not provide enough explanation about side effects from the medications or what to expect as a newly-diagnosed person.

- Given that it is not uncommon for providers to be required to see as many as four people per hour, and the time pressures are not likely to be alleviated, how can we practice the principle of trustworthiness and transparency, even with limited time?

(Sample answers: we can link people to peer support or HIV navigators to address questions that cannot be answered within the scope of a brief office visit, we can acknowledge that the time is short and be sure to leave at least 5 minutes at the end of the visit to answer questions.)

Rod spoke about the medical mistrust that many people living with HIV experience.

- How can we work to create trustworthiness through being transparent and authentic?
**SLIDE 65**

**Examples of Trustworthiness**

- Making sure people really understand their options
- Being authentic
- Directly addressing limits to confidentiality

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**TALKING POINTS**

- One of the most powerful ways of building trust is to give people full and accurate information. Just telling people what’s going on and what’s likely to happen next can be very important.

- Being clear is essential. Telling people they have more control than they really do will eventually destroy trust. For example, calling a program “peer-run” when in fact key decisions are made by the host organization is not trustworthy. It is much better to explain what decisions are made by peers and what decisions are not.

- Sharing your own reactions and responses in a truthful manner and authentic manner is also essential. Trauma survivors often have finely tuned “radar” to detect other people’s emotional states—they have had to develop this capacity, a form of vigilance, to protect themselves. If you are untruthful about your feelings—even if you are trying to protect the other person—they are likely to detect it.

- Directly address the limits to confidentiality and when you would have to disclose information. It is better to tell the individual up front rather than to assure them of confidentiality and then break that trust. For example, Trans Lifeline has mandated reporting guidelines for peer support call line operators in the United States and Canada. The guidelines state: “We explain that if they disclose an abuse situation or intention to self-harm might, that person may intervene in ways that get emergency personnel involved. Help them figure out what they want to share and what they prefer (for now at least) not to disclose to a mandated reporter. *No entrapment!*"
**SLIDE 66**

**Reflection Points**

- How can you promote trust throughout your organization?
- Do the people being served trust your staff?
  - How do you know?
- What changes could be made to address trust concerns?

**INSTRUCTOR GUIDANCE**

*Ask audience for answers to the questions on the slide.*

**SLIDE 67**

**Principle 3: Peer Support**

Peer support and mutual self-help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing, and maximizing a sense of empowerment.

**TALKING POINTS**

- In this context, the term “peer” refers to individuals with lived experiences of trauma.
- Peer support is being used in innovative and exciting ways in a variety of health care settings serving people living with HIV and mental health or substance use conditions.

**SLIDE 68**

**Examples of Peer Support**

- Peer support = a flexible approach to building mutual, healing relationships among equals, based on core values and principles.
- Peer support is:
  - Voluntary
  - Nonjudgmental
  - Respectful
  - Reciprocal
  - Empathetic
TALKING POINTS

- Peer support is not a “service model”—it 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 by taking away choice and voice.

- Peer support is not “Peer Counseling,” which implies that one person knows more than the other—peer support is about power-sharing.

- The heart of peer support involves building trust. 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.

- Trauma-informed peer support is not just important for people who receive services. It is important that staff who are trauma survivors have access to peer support, too.

SLIDE 69

Video on peer support

INSTRUCTOR GUIDANCE

Video is at https://youtu.be/NAXAYUTik1I

Please show the video and ask participants the following questions:

Debbie points out how peer support is especially vital in her community for “uplifting one another.”

- How can peer support help people who have experienced trauma to find hope and navigate living with HIV?

Robert talks about how “connection can make or break someone.”

- How do you involve peer support or HIV navigators in helping people living with HIV to feel less alone?
• How can peer support workers help people living with HIV to stay engaged in care?
  (Sample answers: calling people to remind them of their appointments, to discuss barriers to engaging in care, to listen if they have had a bad day, to educate them about fears around living with HIV and navigating disclosure.)

SLIDE 70

Benefits of Peer Support

• Peers model and encourage recovery and self-management.
• Helps to address factors affecting engagement.
• Reduces the isolation associated with trauma, HIV/AIDS, and mental or substance use conditions—“I’m not alone.”
• Serves as a bridge between persons receiving services and community resources.
• Establishes a sense of safety and hope, builds trust, enhances collaboration, and maximizes a sense of empowerment.

TALKING POINTS

• As noted in the slides about healing from trauma, relationships are where healing happens.
• Peer support allows authentic connections to be made with others with lived experience. It can be very healing to talk with someone who has similar experiences and has found ways to heal.
• Peer support also offers non-judgmental relationships where people living with HIV can be open and honest about their experiences, fears, hopes, and lives.
• Remember, relationships matter!

SLIDE 71

Ruth M. Rothstein CORE Center

• Integrated peer support throughout service delivery
• Builds trust and a solid foundation for improved patient–provider relationships.
• Peers’ roles include:
  — Educating providers throughout a large hospital system
  — Assisting with the transition from inpatient to outpatient care
  — Orienting new patients to outpatient clinic services

TALKING POINTS

• Here is one example of an effective use of peer support.
• This is a clinic for the prevention, care, and research of HIV/AIDS and other infectious diseases located in Chicago, Illinois. It is one of the largest HIV/AIDS providers in the United States and part of the Cook County Hospital system.

• Peer workers at the Center participate in a 16-week intensive training process. They are integrated as part of team meetings, clinic meetings, and they participate in dialogues about patient care. Peers also participate on the Centers Consumer Advisory Board and participate in conducting research. Some of the other roles played by peers at the Center include acclimating patients to clinic, helping to connect them with services in the community, and conducting new patient orientations.

• Also, when someone anywhere in the Cook County Medical Center is diagnosed as HIV positive, a peer supporter from the CORE Center asks to meet with them to provide support, talk to them about their own experience, and let them know what services the CORE Center can provide, including support groups, pharmacy, an HIV clinic, and physician follow-ups. If individuals come to the CORE Center, the peers follow them in almost a case management capacity. For example, if the client is coming in to see the physician, if desired, the peer supporter will be present to meet with them and support them.

  o There are so many benefits to peer involvement," says Katie Howe, case manager at the CORE Center. “When our new patients come for their first visit, the tour is led by a peer advocate. They introduce themselves and when appropriate, they can share their personal narratives. This builds trust and a solid foundation for improved patient-provider relationships. Our patients know that ‘I have someone here who understands me, I feel comfortable and not so alone.’"
TALKING POINTS

- Peer-based support has been shown to improve the health outcomes of women living with HIV in ways such as decreasing HIV-related discrimination, increasing HIV testing and linkage to care, decreasing transmission and poor health outcomes, and building partnerships between public health representatives and women living with HIV.
- Common Threads is a peer-led HIV training that addresses social determinants of health as an integrated prevention, trauma-informed, and vocational development training.
- The training is designed to increase self-esteem, sociability, economic well-being, and HIV-self management while at the same time reducing the stigma and resulting silence and isolation associated with HIV.
- This small group training is designed to enhance the ability of women living with HIV to powerfully share their life experiences with each other and others of their choice. The group run by a mental health professional and supported by peer trainers who model the activities, such as storytelling techniques.
- This successful program created a safe environment facilitated by peers and clinical support, which increased participants’ ability to disclose challenging life experiences, including trauma and other vulnerabilities.

INSTRUCTOR GUIDANCE

- Have group discuss questions on the slide.
SLIDE 75

**Principle 4: Collaboration and Mutuality**

- Maximizing collaboration and sharing of power with consumers.
- True partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators.
- Recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
- *Everyone has a role to play; one does not have to be a therapist to be therapeutic.*

TALKING POINTS

- Principle 4 focuses on:
  - Maximizing collaboration and sharing of power with consumers.
  - Leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators.
  - Recognition that healing happens in relationships and meaningful sharing of power and decision-making.
- Everyone has a role to play in trauma-informed approaches; one does not have to be a therapist to be therapeutic.

SLIDE 76

**Video**

[Video on collaboration & mutuality](https://youtu.be/jjnQwbHQME4)

INSTRUCTOR GUIDANCE

Video at [https://youtu.be/jjnQwbHQME4](https://youtu.be/jjnQwbHQME4)

*Please show the video and ask participants the following questions:*

- What are some of the things that Margot and Robert mention can help to foster a more collaborative relationship between health care providers and people using services? *(Sample answers: respecting their time [and offering a sincere apology when appointments are backed up beyond the provider's control] offering a glass of water,)*
inquiring about how the person is, asking “what would work for you?” as pertains to any treatment plans and really listening.)

- How does fostering a collaborative and mutual relationship with people using services strengthen engagement in care and health outcomes? *(Sample answer: when people feel like it’s a collaborative relationship, they are more invested in their health care and are more likely to be fully honest with their providers.)*

**SLIDE 77**

**Examples of Collaboration and Mutuality**

- Use collaborative, therapeutic conversations: Staff communicate in a way that promotes a partnership provided within a culture of caring, empathy, and safety
- Seek to understand the whole person
- Listen carefully for unmet needs that cause disengagement from care

**TALKING POINTS**

- Collaboration and mutuality refers both to collaboration between staff and people served and among different levels of staff.
- The slides list a few ways to enhance collaboration. *[READ BULLETS on SLIDE]*
- Part of collaboration involves getting to know and understand the people you work with (staff and clients), listening intently to their experiences and ideas, and validating their feelings.
- Other ways to implement this principle include shared decision making with the people you serve, building therapeutic relationships, and letting staff, peer support coaches, and clients help create organizational policies.
- Reducing levels of hierarchy in an organization so everyone feels they are an important part of the organization and listened to.

**INSTRUCTOR GUIDANCE**

*Following are some possible activities*

1) You can lead a conversation/exercise where participants change these statements to more collaborative language

- You’ll have to sit and wait like everyone else in this place. The doctor’s behind...it’s not my fault.”
- “You didn’t get your labs drawn? How in the world do you expect the doctor to help you?”
- “I am pleading with you to take your medication. If you don’t you will...”
- “You have to understand that living with HIV means you have to take medication.”
• “You have to make a change or you will die.”

2) **Ask, “What are some ways people react when we ****tell them what to do?”**

- They do the opposite.
- They get tired of it.
- They tune us out.
- They don’t come back for care.
- They feel offended.
- They get angry.
- They comply, but feel upset.


**SLIDE 78**

**Reflection Points**

- What are examples from your agency of true partnership between the staff and the people served?
- What are examples from your agency of partnership between top-level administrators and front-line staff?
- What changes could your organization make that would significantly decrease the power differentials in your agency?

**INSTRUCTOR GUIDANCE**

- **Ask group to discuss questions on the slide.**

**SLIDE 79**

**Principle 5: Empowerment, Voice, and Choice**

- Individuals’ strengths and experiences are recognized and built upon; the experience of having a voice and choice is validated and new skills are developed.
- The organization fosters a belief in resilience.
- Clients are supported in developing self-advocacy skills and self-empowerment.

**TALKING POINTS**

- **Principle 5:**
  - Strengthens clients and family member’s experience of choice
Recognizes that every person’s experience is unique
Is an individualized approach

**SLIDE 80**

**Video**

*Video on empowerment, voice, and choice*

**INSTRUCTOR GUIDANCE**

Video at [https://youtu.be/Se67uu5Xf8Q](https://youtu.be/Se67uu5Xf8Q)

*Please show the video and ask participants the following questions:*

Margot notes how it “makes you feel like the most valued person on the earth” and it “makes you want to work with them,” and “to obtain optimum health and well-being” when a provider “takes an interest in you as a person.”

- How does creating an atmosphere of empowerment encourage people to stay engaged in care?

Sharon mentioned how important it was for her to have control over her medication regimen, including how often, when, and how many pills she takes. She also noted how empowering it was to have a provider listen to her concerns and answer her questions regarding her course of treatment, as well as research taking place in her area.

- How can we as providers help people living with HIV to have more of a sense of voice, choice, and control over their treatment?

**SLIDE 81**

**Examples**

- Ask at intake: “Tell me what talents, strengths, or interests you bring to our community.”
- Include treatment activities designed and led by service recipients.
- Turn “problems” into strengths.
TALKING POINTS

• There are many ways to build on people’s strengths and resilience. What are some ways you can use your clients’ strengths?

• Sometimes people want a list of things they should be doing, but this principle reflects a positive, creative attitude rather than a specific technique.

• Empowerment, voice, and choice apply to staff as well as the people served.
  o Find ways to utilize and showcase the strengths of staff and people you serve.
  o Identify ways to offer choice around services or activities.
  o Consider strategies to empower others by making them an integral part of the organization, outreach, engagement of others in services, social media campaigns, and peer support work.

SLIDE 82

Reflection Points

• Can you think of examples from your work setting of empowerment, voice, and choice for the people served?
• What about for staff?
• Can you think of policies or practices that do the opposite—that take voice, choice, and decision-making away? Could any of these things be changed?

INSTRUCTOR GUIDANCE

• Ask group to discuss questions on slide.

SLIDE 83

Principle 6: 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.
TALKING POINTS

- Organizations that put this principle into action are:
  - Actively moving past cultural stereotypes and bias
  - Offering gender-responsive services
  - Levering the healing value of traditional cultural connections
  - Recognizing and addressing historical trauma, such as the discrimination against LGBT populations throughout time, the toll of the AIDS epidemic, the impact of generations of racism or poverty, etc.

INSTRUCTOR GUIDANCE

Video at https://youtu.be/gM0SKqdH1Y

Please show the video and ask participants the following questions:

Debbie talked about the importance of addressing people using services using their preferred gender pronouns and preferred name, even if it differs from their legal name.
- How do you safeguard against mis-gendering people at your agency?
- What are some policies and protocols you can put in place to make sure that transgender and gender non-conforming people feel safe using services at your agency?

Debbie also mentioned the importance of not having one “go-to” person on transgender issues.
- What if that person is out sick or leaves the agency?
- How can you help to ensure everyone at the agency is sensitive to gender issues?

Anna mentioned several issues that African American older adults face, including the “fear of white coats,” based on historical memories of medical experimentation on people of color. She also mentioned the importance of greeting people respectfully and asking people how they would like to be addressed, rather than automatically referring to them by their first names.
- What other ways can you show respect regarding possible cultural values and historical concerns facing people using services at your agency?
Note that both Debbie and Anna spoke to the importance of making eye contact as a show of respect and also maintaining respect for cultures where eye contact is not a positive gesture by asking about it if there is any doubt.

SLIDE 85
Trauma-informed Primary Care Model

UCSF Women’s HIV Clinic

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TALKING POINTS

• In this example, an HIV clinic is putting Principle 6 into action.

• The University of California in San Francisco’s Women’s HIV Clinic is a multidisciplinary clinic that serves 200 women living with HIV, mostly women of color. It was founded in 1993.

• The organization collaborates with community-based organizations to provide services including peer support, creative arts therapies, and other supports.

• The Clinic has assessed trauma in its client population and has piloted two trauma-informed interventions that put an emphasis on cumulative lifetime trauma.

• The Clinic reflected on findings from both its research study and its interventions, and it is identifying a replicable and scalable model—essentially a trauma-informed demonstration project that can be used across the country. It involves intentional integration of training and infusing trauma-informed principles into every service, health care worker, provider, and person who walks into the clinic.
INSTRUCTOR GUIDANCE

- Ask audience to discuss questions on slide.

SLIDE 87

Trauma-informed Care for People Living with HIV

Trauma-informed approaches should incorporate the following (Brezing and Freudenreich, 2015):
- Create a trauma-sensitive practice environment:
  - Includes trainings to ensure a sense of safety in all patient interactions with staff members, including physicians, clinical staff, and administrative staff
- Identify trauma and ways it can cause barriers to care:
  - Including after-effects of posttraumatic stress, including poor adherence to treatment and high-risk behaviors
- Educate people living with HIV about the connection between trauma and its negative behavioral and physical health outcomes.
- Link people living with HIV with suitable resources and referrals for more specialized support as needed.

TALKING POINTS

- In the next section, we will explore how in our interactions we can promote a sense of healing, using a case study.

Reference:

### TALKING POINTS

**•** In this section we reviewed the four Rs of a trauma-informed program, organization, or system, which means it:

- Realizes widespread impact of trauma and understands potential paths for recovery
- Recognizes signs and symptoms of trauma in clients, families, staff, and others involved with the system
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices
- Seeks to actively resist re-traumatization.

**•** Additionally, we discussed the six principles of a trauma-informed response:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender issues

**•** A trauma-informed approach is founded on the belief that people are resilient and can recover or heal. Trauma-informed approaches strive to build resiliency by actively resisting retraumatization and developing a supportive environment by putting the six principles and four Rs into play.

**•** A trauma-informed approach is applicable for every service setting, but particularly in HIV service settings, because so many people have experienced trauma and, as we
explored in the last section, are more at risk of dying from trauma related issues than HIV itself.

**SLIDE 89**

Section 5: Healing & Recovery

**SLIDE 90**

**Learning Objectives**

- After completing this section, you will be able to:
  - Describe recovery from trauma.
  - Think about what your system can do differently to enable healing.
  - Reflect on changes needed to implement trauma-informed approaches in your work and organization to focus on healing.

**TALKING POINTS**

After completing this section, you will be able to:

- Describe recovery from trauma.

- Think about what your system can do differently to enable healing.

- Reflect on changes needed to implement trauma-informed approaches in your work and organization to focus on healing.
As Dr. Machtinger said in the last section, we need to be looking beyond the single goal of viral suppression and support people to heal from trauma that will affect both their HIV outcomes, as well as other health and social outcomes.

The terms used for “recovery” from trauma can differ among different work settings, organizations, and cultures.

Whatever terms is used, the end goal is for any person who has experienced trauma to heal enough to live a satisfying and meaningful life, regardless of what happened to them or what health challenges they are living with.

Trauma does not have to be a life sentence to pain, depression, anger, fear, or any other emotion or behavior.

Healing is possible for everyone. As providers, our role is to help nurture that healing process.

Next, we will look at concrete strategies in the clinic to support the people we work with who have experienced trauma.
INSTRUCTOR GUIDANCE

Video at [https://youtu.be/0DXHkdzgkq4](https://youtu.be/0DXHkdzgkq4)

Please show the video and ask participants the following questions:

- Anna speaks about the importance of asking the people we work with about how trauma has impacted them.
  - Do you currently have any protocols in place for assessing the trauma history of people you work with, as well as screening for current trauma, such as intimate partner violence?
  - Why or why not?

- We will proceed in the next slides to explore a framework using a case study on how we can sensitively begin a discussion about trauma with the people we work with, using a limited disclosure methodology, even if we do not have a lot of time.

- It goes without saying that before we do any trauma-related assessment with the people we serve, it’s vital to have in place the ability to provide appropriate referrals to accessible and affordable trauma-specific services and supports, including trauma-informed peer supports.

SLIDE 94

The 4 Cs: Promoting Healing in Relationships

- Calm
- Contain
- Care
- Cope

Source: Kimberg, 2016
INSTRUCTOR GUIDANCE

- While these terms are suggested language for framing the discussion, feel free to be authentic and use whatever terms are more natural for you.

TALKING POINTS

- This framework of the 4 Cs was developed by Dr. Leigh Kimberg, professor of Medicine in the Division of General Internal Medicine at UCSF (Kimberg, 2016). She collaborates closely with the UCSF Women’s HIV Clinic in helping them to develop their trauma-informed model of primary care for women living with HIV.

- We will utilize a case study to explore how to use these elements in practice. These are all connected with a sense of safety and establishing respectful relationships with people using services, so that they will want to continue to engage in care and access resources for healing.

Reference:


SLIDE 95

**Case Study: Ms. Jones**

- Ms. Jones is 44-year-old woman who comes to her first primary care visit complaining of pain and insomnia.
- She has diabetes and asthma—both are poorly controlled.
- She is HIV+ but does not attend her appointments regularly and is not adhering to her medications, with increasing viral load.
- She seeks care frequently in the ED for pain and shortness of breath, where she has been noted to smell strongly of alcohol.
- She is very upset that you are late for her appointment.

Source: Adapted from Dr. Leigh Kimberg, 2016

TALKING POINTS

- How could we provide a trauma-informed approach to this appointment? We know that being late is not a “trauma informed practice,” but it happens in reality and is often out of our control.

- How would you approach working with her using the principles we discussed?
Example:

- **Trustworthiness and transparency:** Acknowledge that you’re late, apologize, and validate her experiences. “I am so very sorry that I’m late. I know it’s really frustrating to have to wait and not know when you are going to be seen.”

Reference:


**SLIDE 96**

**TALKING POINTS**

- How could we provide a trauma-informed approach to this appointment? We know that being late is not a “trauma informed practice,” but it happens in reality and is often out of our control.
- How would you approach working with her using the principles we discussed?

Example:

- **Trustworthiness and transparency:** Acknowledge that you’re late, apologize, and validate her experiences. “I am so very sorry that I’m late. I know it’s really frustrating to have to wait and not know when you are going to be seen.”

Reference:

TALKING POINTS

• This framework was developed by Josh Korda, a mindfulness teacher and psychologist who has experience working people with severe addiction and is himself a survivor of trauma. It works well in a busy office because everyone has 90 seconds. You can do this in a toilet stall, if necessary!

• Longer outbreaths activate the parasympathetic nervous system.

Reference:


TALKING POINTS

• We assume a trauma, even if is not known or disclosed, knowing the high prevalence of lifetime trauma in the lives of people using services.

• The primary purpose of the visit is to establish a healing and healthy relationship. Prioritize safety.

• De stigmatize—of course it makes sense that she is using alcohol as a coping technique.
• Focus on her strengths and resilience—shame is such a common feature for so many people.

• Pay attention to power dynamics—be mindful of structural violence and experiences of racism or homophobia/transphobia.

• Once a trusting relationship has been developed, it can be possible explore issues around race and gender and how this relationship is working for the person using services.

Reference:


SLIDE 99

Ms. Jones: Trauma History

• Ms. Jones’ father was incarcerated for domestic violence when she was 10. Her uncle moved in to "help out" but sexually abused her for 3 years. Ms. Jones began drinking at age 10 and did very poorly in school. She was placed in a group home at age 13 when her mother felt she was “out of control.”

• She contracted HIV 5 years ago from an abusive boyfriend who passed away a year ago.

• Ms. Jones remembers a favorite aunt as the only person she ever felt truly loved her.

Source: Adapted from Dr. Leigh Kimberg, 2016

TALKING POINTS

• Here is the trauma history for Ms. Jones from our case study.

Reference:


SLIDE 100

CONTAIN

Introduce or ask about the topic of trauma in a way that:

• Will allow the person to maintain emotional/physical safety.

• Offers choice and control.

• Respects the timeframe for your interaction.

• Allows you to offer them further trauma-specific treatments without disclosure.

Source: Dr. Leigh Kimberg
TALKING POINTS

• Although bringing up trauma is very important, we need to be mindful of how we do it, especially if you do not have a lot of time with someone.

• The primary goal is for the encounter feel healing and not re-triggering, so she will want to come back.

• We want to ensure that the person feels in control of what they do and don’t reveal.

• Ask in a way that offers choice and control.

Reference:

SLIDE 101

Nondisclosure-based Universal Trauma Education

• Nondisclosure-based education about trauma is likely the safest way to introduce this topic—it gives the person more control and choice.

• Time constraints: Do not inquire directly about trauma if you do not have time to listen compassionately to the answer.

• Trauma-specific service referrals can be offered without the need for very much or any disclosure.

Source: Dr. Leigh Kimberg, 2016

TALKING POINTS

• You can offer assistance without disclosure.

Reference:
SLIDE 102

Signs Indicating Lifetime Trauma

- Young age of onset of substance use or mental health problem or first sexual experience is highly suggestive of trauma.
- Consider asking age of onset, if appropriate.
- “How old were you when you first started drinking alcohol?”
- “How old do you think you were when you first ever became depressed?”

Source: Dr. Leigh Kimberg, 2016

TALKING POINTS

- You might be amazed how many people you work who will reveal that they can’t remember a time when they were not depressed.

Reference:


SLIDE 103

Framing the Conversation

- “How we were treated when we were children can affect our health later in life, so I would like to ask you about your childhood, if that is okay.”
  - “Who did you grow up with? (parent[s], grandparent[s], others?)
  - “How did [insert person[s]] treat you?”
- Provide examples if unclear: “Sometimes family members cheer you on and support you and sometimes family members criticize you, put you down, hurt you, or hit you.”
  - “How did [insert person[s]] treat you?”

Source: Dr. Leigh Kimberg, 2016

TALKING POINTS

- Frame the conversation and why you are asking; this corresponds with trustworthiness and transparency.
- Provide examples for clients, as they may not know that this is an appropriate topic of discussion in a healthcare setting.

Reference:

SLIDE 104

Framing the Conversation (cont.)

So, for example, when Ms. Jones tells you on the very first visit that she first began drinking at age 10, you can say something like this:

“In my experience, when someone tells me that she began drinking at age 10, it’s often because she was experiencing very difficult things during childhood. We are just meeting each other for the first time today, so we don’t need to go into those details right now. I do want you to know that I am open to discussing those things with you in the future, or I can connect you with a counselor you can talk to if you think that would be helpful.”

TALKING POINTS

• Assume it might be triggering to get into depth on this first visit. Offer choices, in keeping with voice, choice, and empowerment.

SLIDE 105

CONTAIN

• Ms. Jones discloses trauma briefly without obvious distress.
• Acknowledge courage: “Thank you for sharing this information with me.”
• Provide validation and support: “I am so sorry this happened to you.”
• Inquire about impact: “How do you feel this experience has affected you?”

Source: Dr. Leigh Kimberg, 2016

TALKING POINTS

• Some will acknowledge they have a trauma history and mention supports in their church, therapy, family, or community.

• Consider asking: “How is it impacting you today?”

• As one example, a woman said she works with children and feels very overprotective and stressed at her job due to her own childhood experiences, and she felt like this was hampering her job performance.

Reference:

TALKING POINTS

• Emphasize that we can get into this gradually. The most important thing is that we are able to continue working together, and that this feels like a healing place.

• If the person is open to it, take them through a quick grounding exercise and explain the purpose of grounding.

Reference:


TALKING POINTS

• Create a non-judgmental space for person, so that whatever he/she feels— even if it's intense love for someone who has hurt or is hurting them—is ok.

Reference:

SLIDE 108

CARE (cont.)

- Express care and compassion (especially about stigmatized behaviors and conditions).
- “No wonder you started drinking when you were 10. It was so important for you to find a way to cope with an impossible and painful situation.”
- “It can be very hard to learn to take good care of yourself when you were hurt as a child.”
- “We all deserve to be treated well. I am so sorry those things happened to you.”

Reference:


SLIDE 109

COPE

- Emphasize skills and interventions that build on strength, resilience, social connectedness, and hope.
- Support people to identify as the survivor they actually are!
  - “You’ve managed to survive in very difficult circumstances.”
  - “I’m so glad you had the courage to reach out for help today.”
  - “I hear how loved you felt by your favorite aunt. It sounds like she was really important in your life.”

Reference:


TALKING POINTS

- Remember—healing happens in relationship.
- People often feel like they have failed, or carry guilt, shame, or internalized stigma.
- Highlight their strengths.
- Remind them of any good relationships they have had, of that healing, that love.
Reference:


**SLIDE 110**

**COPE (cont.)**

- **Coping techniques:**
  “When you feel stressed, what do you do to cope?”
- **Discuss** the benefits of adverse coping techniques:
  “It sounds like alcohol really helps you cope. How does it help you? What do you like about drinking?”
- **Discuss** alternatives:
  “Can you think of anything else besides alcohol that also helps you feel better?”

**TALKING POINTS**

- Don’t worry about the just the right questions. There is no perfect technique for talking about coping. You can just ask, “When you feel stressed, what do you do to cope?”

- By and large most people will be able to think of one alternative coping skill.  

  *One woman pulled out her phone and said, “whenever I feel suicidal I listen to this Ocean app.”*

- Asking people what works for them and encourage them to explore alternative coping strategies

**SLIDE 111**

**Provide Resources**

Connect people with local trauma-healing resources in your agency or in the community:

- Counselors specializing in trauma-specific interventions
- Music, dance, or movement classes
- Other creative/expressive arts opportunities
- Accessible and affordable mindfulness or yoga classes
- Trauma-informed peer support
INSTRUCTOR GUIDANCE

It goes without saying that it’s important to have connections and resources ready to suggest before we open up any conversations about trauma.

SLIDE 112

**Reflection Points**

• What is one thing you or your organization could do differently to enable healing?
• Describe one thing you are currently doing to help people heal from trauma?
  – Does it tie into any of the six principles of a trauma-informed approach and the four Cs?

SLIDE 113

**Section 5: Summary of Key Points**

• Healing from trauma is possible for everyone.
• Safety is essential in establishing healing relationships and environments.
• The four Cs:
  1. Calm
  2. Contain
  3. Care
  4. Cope

SLIDE 114

“I’ve learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.”

—Dr. Maya Angelou
INSTRUCTOR GUIDANCE

*This section is intended for organizational leaders. If your training is for direct-care staff, this section may not be very applicable to their work. The section is an optional part of the training.*

**TALKING POINTS**

- The change process to become a trauma-informed organization is conscious, intentional, and ongoing.

- The organization should become a learning community, constantly responding to new knowledge and developments.

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**SLIDE 116**

**Learning Objectives**

- Describe why change is required at multiple levels of an organization.
- Identify the organizational domains involved in creating a trauma-informed organization.
- Describe three ways your organization can make changes to become more trauma informed.

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**TALKING POINTS**

After completing this section, you will be able to:

- Describe why change is required at multiple levels of an organization.
- Identify the organizational domains involved in creating a trauma-informed organization.
- Describe three ways your organization can make changes to become more trauma informed.
TALKING POINTS

• Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment with the six key principles we just discussed.

• The guidance provided here builds upon the work of Harris and Fallot. In conjunction with the key principles, it provides a starting point for developing an organizational trauma-informed approach. While it is recognized that not all public institutions and service sectors attend to trauma as an aspect of how they conduct business, understanding the role of trauma and a trauma-informed approach may help them meet their goals and objectives.

• Organizations, across service-sectors and systems, are encouraged to examine how a trauma-informed approach will benefit all stakeholders; to conduct a trauma-informed organizational assessment and change process; and to involve clients and staff at all levels in the organizational development process.

• The guidance for implementing a trauma-informed approach is presented in the ten domains described below. This is not provided as a “checklist” or a prescriptive step-by-step process.
• These are the domains of organizational change that have appeared both in the organizational change management literature and among models for establishing trauma-informed care. What makes it unique to establishing a trauma informed organizational approach is the cross-walk with the key principles and trauma-specific content.

SLIDE 119

Domain 1: Governance and Leadership

• The leadership and governance of the organization support and invest in implementing and sustaining a trauma-informed approach.
• There is an identified point of responsibility within the organization to lead and oversee this work, and inclusion of the peer voice is needed.
• A champion of this approach is often needed to initiate a systems-change process.

SLIDE 120

Reflection Point

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

• How does agency leadership communicate its support and guidance for implementing a trauma-informed approach?
• How do the agency’s mission statement and/or written policies and procedures include a commitment to providing trauma-informed services and supports?
• How do leadership and governance structures demonstrate support for the voice and participation of people using services who have trauma histories?
SLIDE 121

**Domain 2: Policies and Protocols**

- There should be written policies and protocols establishing a trauma-informed approach as an essential part of the organizational mission.
- Organizational procedures and cross-agency protocols, including working with community-based agencies, should reflect trauma-informed principles.

TALKING POINTS

- This approach must be “hard-wired” into practices and procedures of the organization, not solely relying on training workshops or a well-intentioned leader.

SLIDE 122

**Reflection Point**

INSTRUCTOR GUIDANCE

*Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:*

- How do staffing policies demonstrate a commitment to training on providing services / supports as part of staff orientation and in-service training that are: Culturally relevant? Trauma-informed?
- What policies and procedures are in place for including trauma survivors/people receiving services and peer supports in meaningful and significant roles in agency planning, policy-making, services, and evaluation?
- How do written policies and procedures:
  - Include a focus on trauma and issues of safety and confidentiality?
- Recognize the pervasiveness of trauma in the lives of people using services, and express a commitment to reducing re-traumatization and promoting well-being and recovery?

**SLIDE 123**

**Domain 3: Physical Environment**

- The organization ensures the physical environment promotes a sense of safety and collaboration.
- The physical setting supports the collaborative aspect of a trauma-informed approach through openness, transparency, and shared spaces.

**TALKING POINTS**

- Staff and individuals being served must experience the setting as safe, inviting, and not a risk to their physical or psychological safety.

**SLIDE 124**

**Example**

**TALKING POINTS**

- To enhance the physical environment at Western Maryland Hospital, pets are welcomed visitors.
INSTRUCTOR GUIDANCE

*Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:*

- How does the physical environment of your organization promote a sense of safety, calming, and de-escalation for clients and staff?
- How can organizations provide space that both staff and people receiving services can use to practice self-care?
- How can organizations address gender-related physical and emotional safety concerns?

SLIDE 126

**Domain 4: Engagement and Involvement**

People with lived experience should have significant involvement, voice, and meaningful choice at all levels and in all areas of organizational function.

**TALKING POINTS**

- Examples include giving people with lived experience, including those receiving services and peer support a voice within:
  - Program design,
  - Implementation,
  - Service delivery,
Quality assurance procedures,

Cultural competence training,

Access to trauma-informed peer support,

Workforce development, and

Evaluation processes and service improvements.

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

- How do people with lived experience have the opportunity to provide feedback to the organization on quality improvement processes for better engagement and services?

- How do staff members keep people fully informed of rules, procedures, activities, and schedules, while being mindful that people who are frightened or overwhelmed may have difficulty processing information?

Collaboration across sectors is built on a shared understanding of trauma and principles of a trauma-informed approach.
TALKING POINTS

• Although a trauma focus may not be the stated mission of various service sectors, understanding how awareness of trauma can help or hinder achievement of an organization’s mission is a critical aspect of building collaborations.

• People with significant trauma histories often present with complex needs, crossing various service sectors. Even if a mental health clinician is trauma-informed, a referral to a trauma-insensitive program could then undermine the progress of the individual.

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

• How does the organization identify community providers and referral agencies that have experience delivering evidence-based trauma services?

• What mechanisms are in place to promote cross-sector training on trauma and trauma-informed approaches?

SLIDE 130

Domain 6: Screening, Assessment, and Treatment Services

• Practitioners use and are trained in screening and assessment methods and interventions that:
  – Are based on the best available empirical evidence and science
  – Are culturally appropriate
  – Reflect the principles of a trauma-informed approach
TALKING POINTS

• Trauma screening and assessment are an essential part of the work.

• Trauma-specific interventions are acceptable, effective, and available for individuals and families seeking services.

SLIDE 131

Reflection Point

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

• Is timely trauma-informed screening and assessment available and accessible to individuals receiving services?

• Does the organization have the capacity to provide trauma-specific treatment or refer to appropriate trauma-specific services?

SLIDE 132

Domain 7: Training and Workforce Development

The organization’s human resource system incorporates trauma-informed principles in hiring, supervision, staff evaluation; procedures are in place to support staff with trauma histories or those experiencing significant secondary traumatic stress or vicarious trauma resulting from exposure to and working with individuals with complex trauma.
TALKING POINTS

• Ongoing training on trauma and peer-support are essential in developing a trauma-informed staff, organization, and organizational culture.

SLIDE 133

Reflection Point

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

• How does the agency ensure that all staff receive training on trauma, its impact, and strategies for trauma-informed approaches across the agency and across personnel functions?

• What types of training and resources are provided to staff and supervisors on incorporating trauma-informed practice and supervision in their work?

• What workforce development strategies are in place to assist staff in working with peer supports and recognizing the value of peer support as integral to the organization’s workforce?

SLIDE 134

Domain 8: Progress Monitoring and Quality Assurance

There is ongoing assessment, tracking, and monitoring of trauma-informed principles and the effective use of evidence-based, trauma-specific screening, assessments, and treatment.
TALKING POINTS

• This principle is important to ensure that trauma-informed approaches are truly being implemented by staff and making improvement when needed.

SLIDE 135

Reflection Point

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

• How can your organization monitor progress in being trauma-informed?
• How does your organization solicit feedback from both staff and individuals receiving services?
• What strategies and processes does the agency use to evaluate whether staff members feel safe and valued at the agency?

SLIDE 136

Domain 9: Financing

Financing structures are designed to support a trauma-informed approach.
TALKING POINTS

This includes an organization offering the financial resources for:

- Staff training on trauma, key principles of a trauma-informed approach;
- Development of appropriate and safe facilities;
- Establishment of peer-support;
- Provision of evidence-supported trauma screening, assessment, treatment, and recovery supports; and
- Development of trauma-informed cross-agency collaborations.

INSTRUCTOR GUIDANCE

Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:

- How does the agency’s budget include funding support for ongoing training on trauma and trauma-informed approaches for leadership and staff development?
- What funding exists for cross-sector training on trauma and trauma-informed approaches?
- What funding exists for peer specialists?
- How does the budget support provision of a safe physical environment?
TALKING POINTS

- Organizations must evaluate how, and how well, trauma-informed approaches are being put into place. Without evaluations, it is difficult to know what is working, what is not working, areas for improvement, and overall outcomes.

- Evaluations can also be helpful when you are looking for additional financing for trauma-informed programs and need to show they are having a positive impact on clients, staff, outcomes, and the organization as a whole.

INSTRUCTOR GUIDANCE

*Each domain has a selection of questions. You can choose one that is relevant to the audience or come up with your own question:*

- What processes are in place to solicit feedback from people who use services and ensure anonymity and confidentiality?

- What measures or indicators are used to assess the organization’s progress in becoming trauma-informed?
• What outcomes do you want to measure that relate to trauma-informed approaches?

SLIDE 140

Discussion of the 10 Domains

• How do the 10 domains interrelate to help organizations implement and sustain trauma-informed approaches?
• Which domains does your organization already address well? Where do you need the most work?

SLIDE 141

Section 6: Summary of Key Points

• The 10 SAMHSA domains are the “interventions,” or ways you will achieve the six principles of trauma-informed care.
• Developing a trauma-informed approach requires change at multiple levels of an organization and the systematic alignment of the 10 domains with the six principles of trauma-informed care.

TALKING POINTS

The 10 Domains are:

• Governance and leadership
• Policy
• Physical environment
• Engagement and involvement
• Cross-sector collaboration
• Screening, assessment, and treatment
• Training and workforce development
• Progress monitoring and quality assurance
• Financing
• Evaluation

• Developing a trauma-informed approach requires change at multiple levels of an organization and systematic alignment of the 10 domains with the six principles of trauma-informed care.

• The 10 domains can be used in leadership meetings to discuss how a trauma-informed approach will benefit all stakeholders at your organization and ways to put the approach into place.

SLIDE 142

Considering the Future

1. What domain(s) is/are your organization’s strength and why?

2. Which domain(s) will you work on in the near future and why?

INSTRUCTOR GUIDANCE Ask people to share answers in the chat box. Read some of the answers, or let people speak, then encourage participants to continue thinking about ways to incorporate this new knowledge into their work.

NOTE: The question on the slide can be changed to best suit your audience or organization.

SLIDE 143

Thank You

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