

Trauma-informed Approach: Improving Care for People Living with HIV

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 (human immunodeficiency virus).



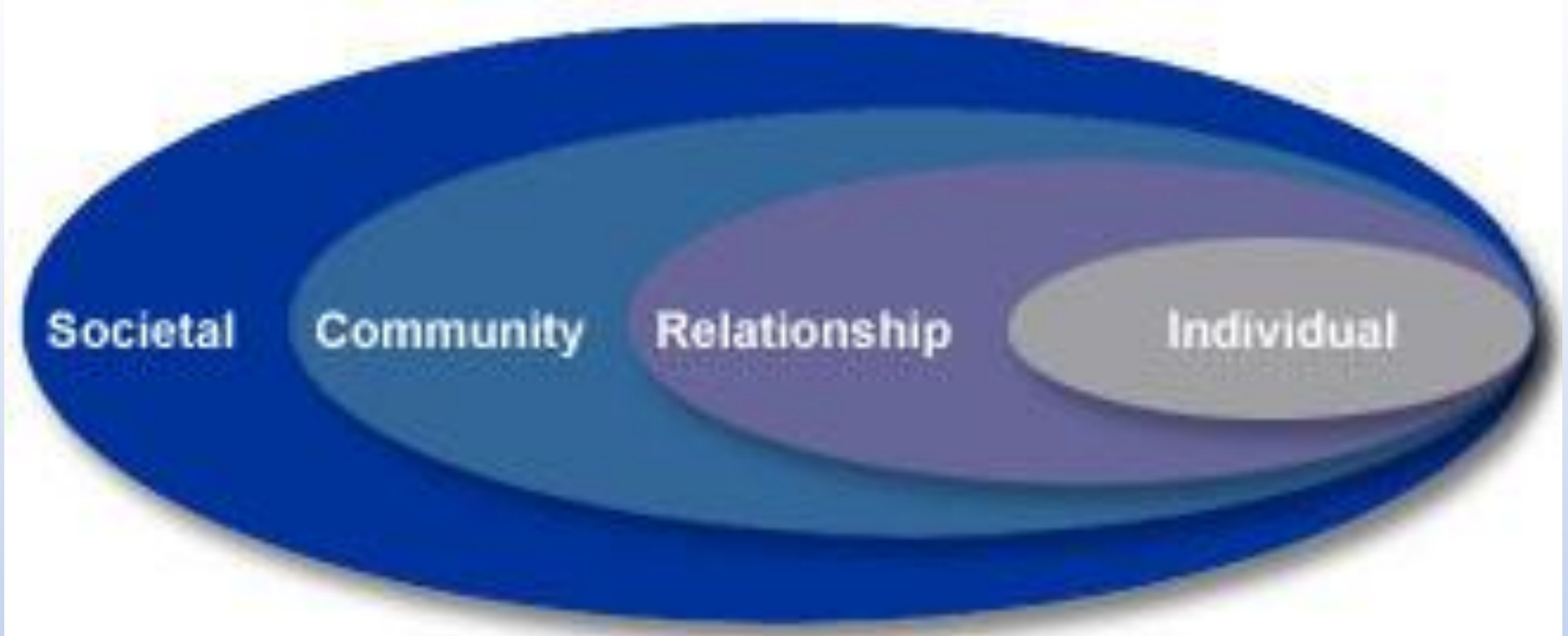
SECTION: 1

What is Trauma?

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.

Social–Ecological Model of Trauma and Resilience



<https://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html>

Things to Remember

- Underlying question = “What happened to you?”
- What are called behavioral health “symptoms” may be adaptations to traumatic events.
- Behaviors have meaning and purpose.
- Healing happens in relationships.

Video: [Power of Empathy](#)

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.



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?”

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.

Potential Traumatic Events—Brainstorm

Abuse

- Emotional*
- Sexual*
- Physical*
- Domestic violence*
- Witnessing violence*
- Bullying/cyberbullying*
- Institutional*

Loss

- Death/loss*
- Abandonment*
- Neglect*
- Separation*
- Natural disaster*
- Accidents*
- Terrorism/war*

Chronic Stressors

- Prejudice/discrimination*
- Racism, homophobia, transphobia, misogyny*
- Invasive medical procedure*
- Disability*
- Poverty*
- Community/historical trauma*
- Health conditions*

Experience of Trauma

- Experience of trauma affected by:
 - How
 - When
 - Where
 - How often



Effect of Trauma

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



Effect of Trauma (cont.)

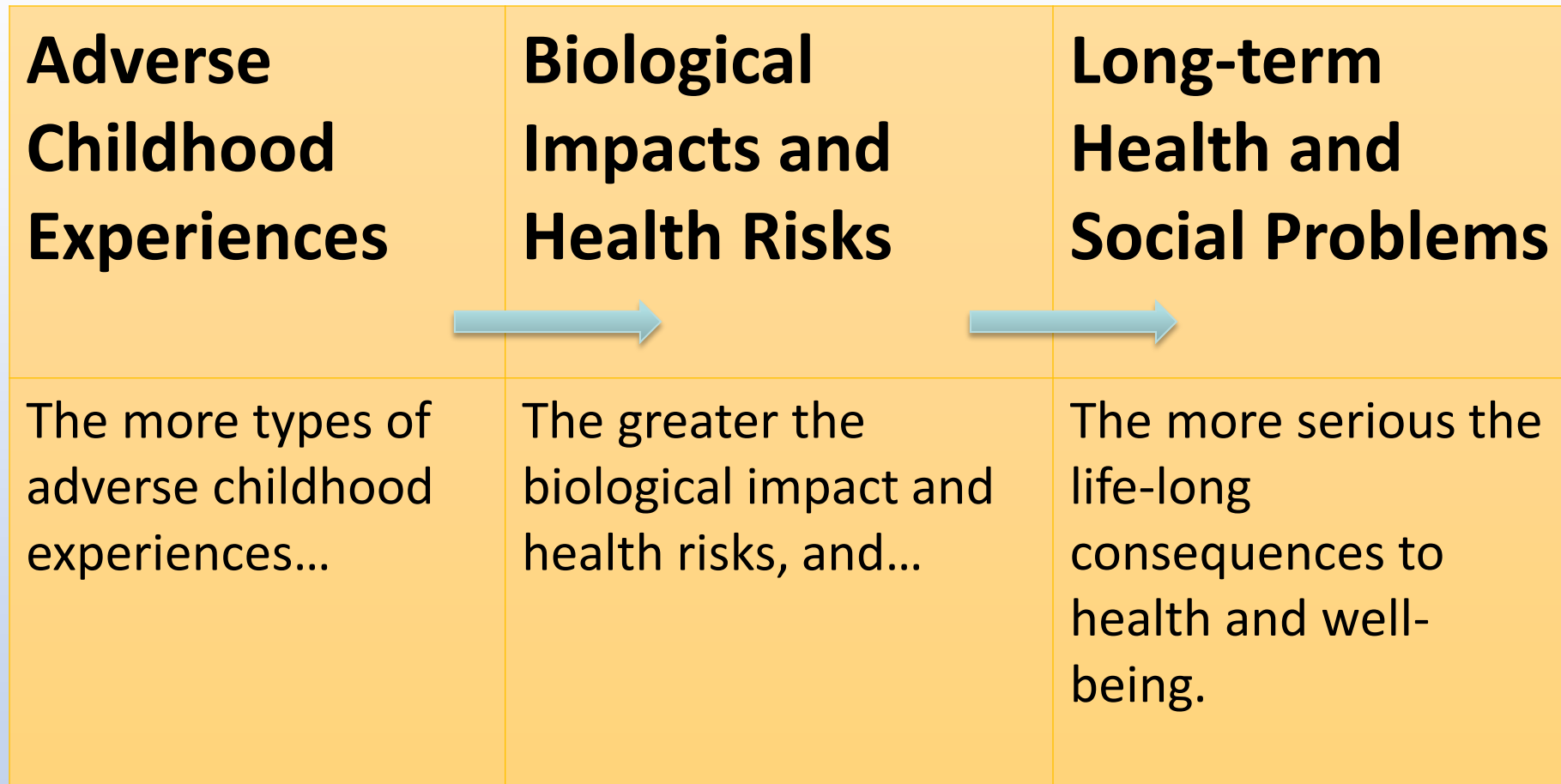
- Trauma can:
 - Cause short- and long-term effects.
 - Affect coping responses, relationships, learning, or developmental tasks.
 - Affect a person's behavior.
 - Affect physiological responses and health, well-being, social relationships, and spiritual beliefs.

Factors Increasing the Impact of Trauma

- Early occurrence
- Blaming or shaming
- Being silenced or not believed
- Perpetrator is a trusted caregiver



Trauma Linked to Health Challenges Over the Lifespan



Felitti et al., 1998

ACE Questions (1–3)

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often or very often... swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?
2. Did a parent or other adult in the household often or very often... push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?
3. Did an adult or person at least 5 years older than you ever... touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

ACE Questions (4–6)

4. Did you often or very often feel that... no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?
5. Did you often or very often feel that... you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
6. Were your parents ever separated or divorced?

ACE Questions (7–10)

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit at least a few minutes or threatened with a gun or knife?
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
10. Did a household member go to prison?

Childhood Experiences Affect Health/Social Outcomes

Behaviors:

- Alcoholism and alcohol use
- Substance use
- Smoking
- Early initiation of smoking
- Early initiation of sexual activity
- Multiple sexual partners

Reproductive outcomes:

- Unintended pregnancies
- Adolescent pregnancy

Future violence:

- Risk for intimate partner violence

Health outcomes:

- Depression
- Suicide attempts
- Fetal death
- Sexually transmitted infections (STIs), including HIV
- Health-related quality of life
- Ischemic heart disease (IHD)
- Liver disease
- Chronic obstructive pulmonary disease (COPD)

Social outcomes:

- Homelessness
- Incarceration

<https://www.cdc.gov/violenceprevention/acestudy/index.html>

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.cestudy.org

Video: [What is Addiction?](#)

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ACEs and Life Expectancy

LIFE EXPECTANCY

People with six or more ACEs died nearly **20 years earlier on average** than those without ACEs.



Resilience

- 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.

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

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.

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.

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.

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.

Section 1: Summary of Key Points

- Adverse childhood experiences influence health and social outcomes into adulthood.
- Adverse childhood experiences are correlated with risk factors for HIV.
- Resilience factors can reduce the impact of trauma on a person's life.



Section 2: Trauma & the Body & Brain

Trauma Affects the Brain

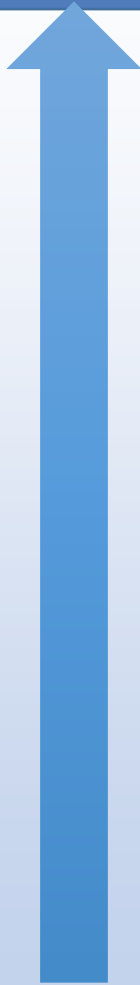
Trauma at any age can affect the brain and result in changes in behavior and responses to life experiences.



Brain Development



Bottom Up Reaction to Fear



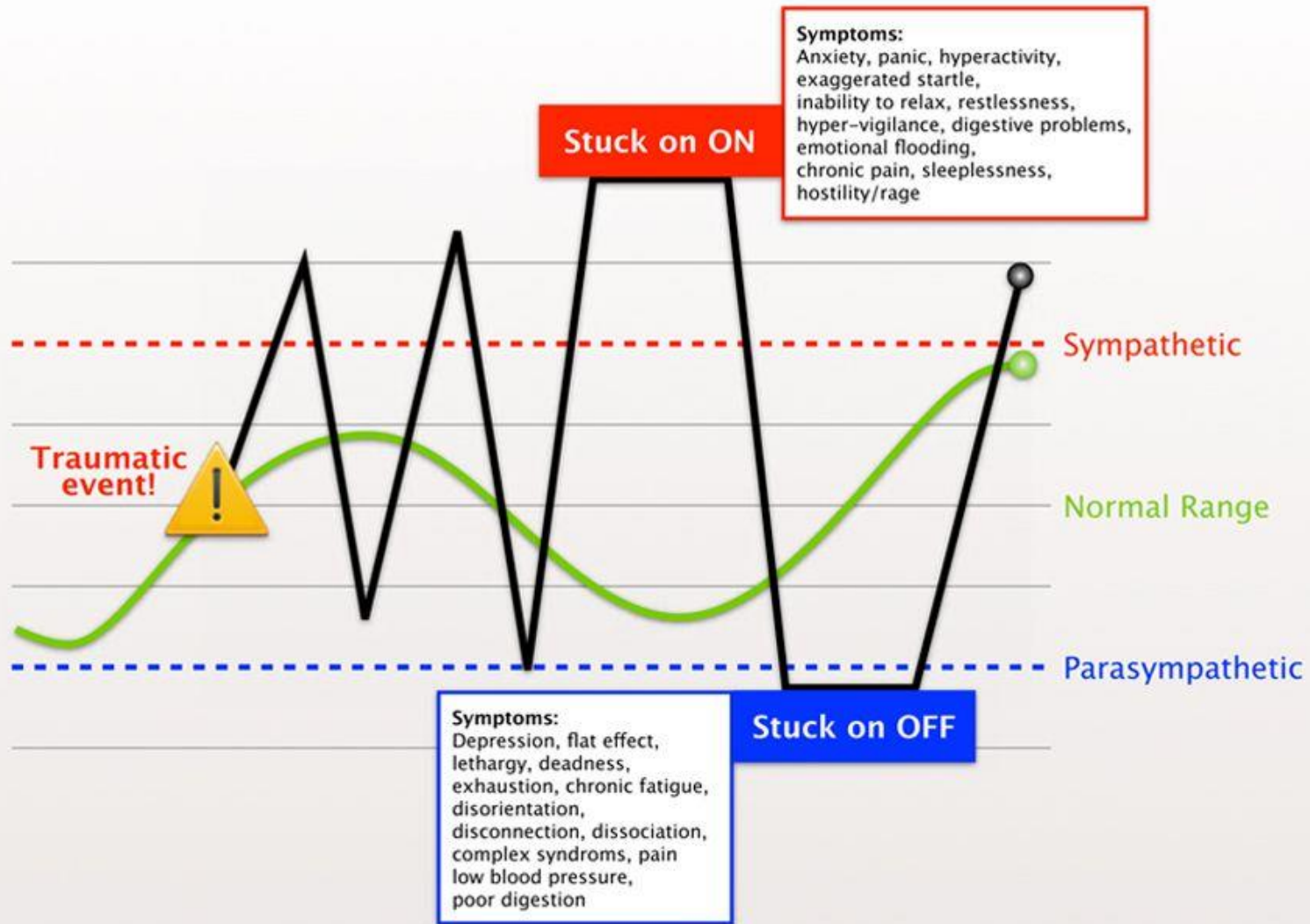
[Video: Toxic Stress Derails Development](#)
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Flight, Fight, or Freeze: The Trauma Response

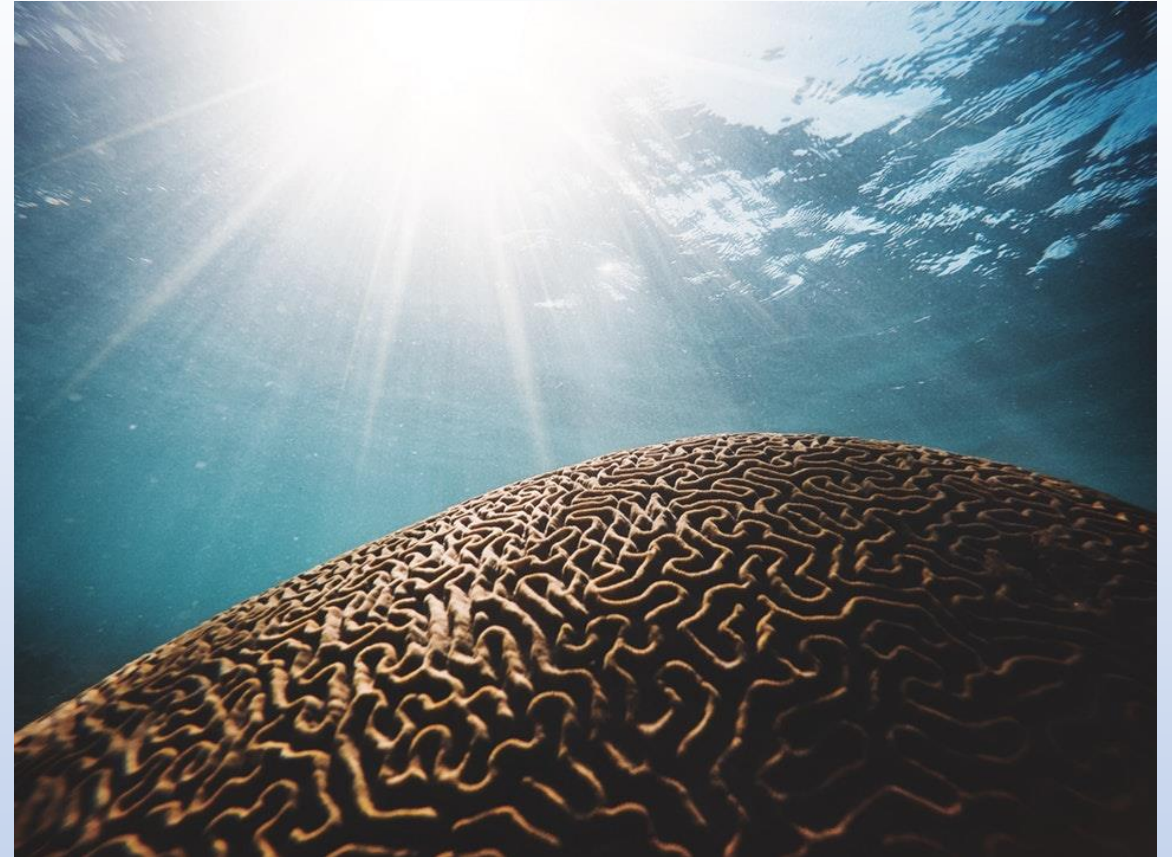
- The brain signals the body to respond to a perceived threat, and the body prepares.
- Ordinarily, when the threat is gone, the body returns to “baseline.”
- But if an ongoing threat is perceived, the body doesn’t return to baseline, remains prepared for threat, resulting in a “trauma response.”
- The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

Symptoms of Un-Discharged Traumatic Stress



The Brain Can Change

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



Source: <https://www.brainline.org/author/celeste-campbell/qa/what-neuroplasticity>

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.



Section 3: Trauma & HIV

“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, researcher, *Coping With HIV/AIDS in the Southeast (CHASE) Study*

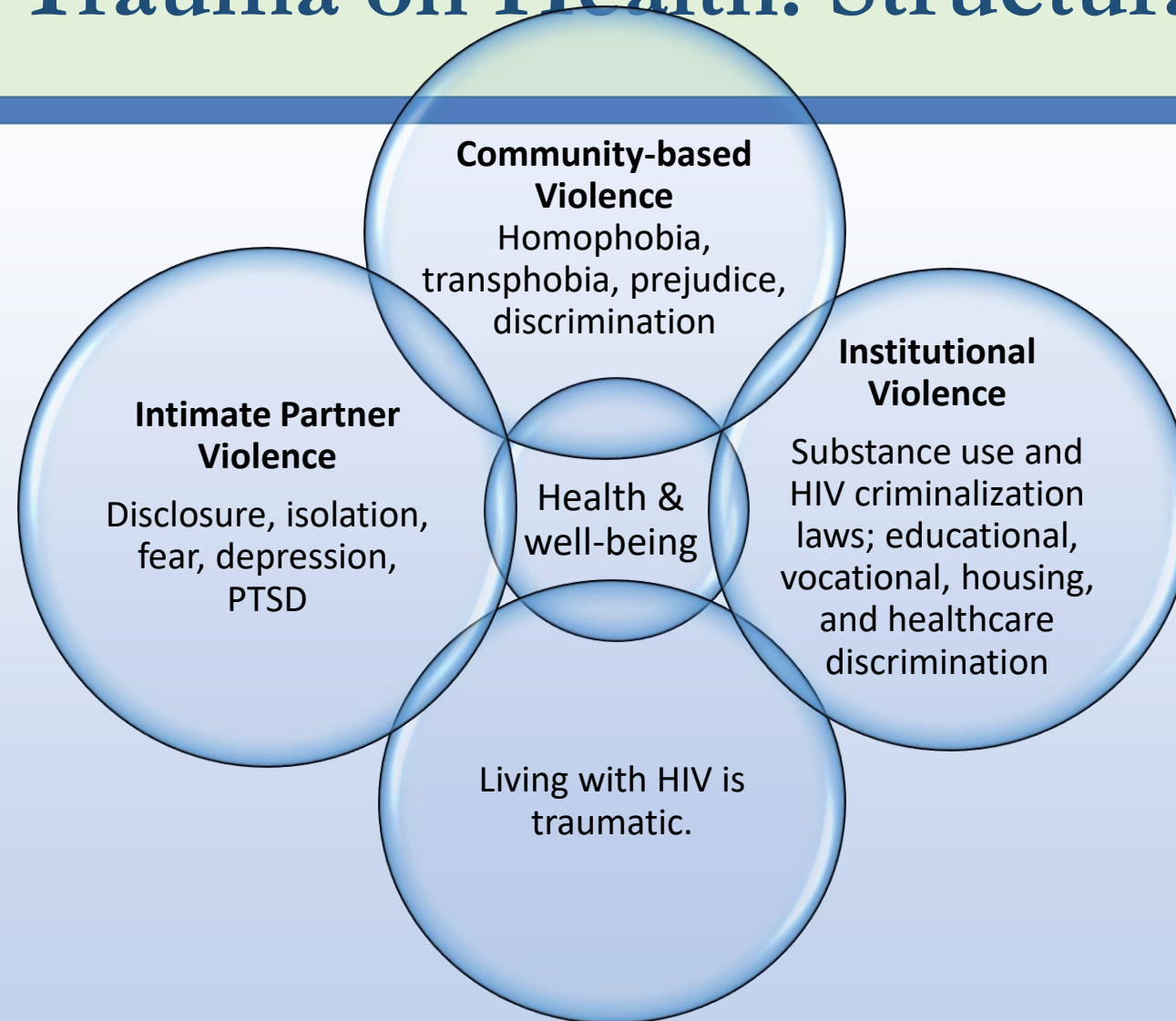
Trauma and HIV: What's the Connection?

- PLHIV 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 PLHIV than in the general U.S. population.
- PLHIV are also disproportionately affected by adult trauma, including intimate partner violence (IPV).
- Lifetime trauma impacts both HIV-risk behavior and the ability of PLHIV to engage in HIV care.

Why We Must Focus on Trauma

- At the Women's HIV Program at UCSF, of the HIV-positive women that die, 16% die from HIV-related causes (Cochoba, 2015).
- Nationally, only 25% die from such causes (French et al., 2009; Weber, 2015).
- Most women with HIV are dying from violence, suicide, addiction, and other causes **associated with lifelong trauma.**
- HIV (like many other health conditions) is a symptom of a far larger problem: **widespread unaddressed trauma.**

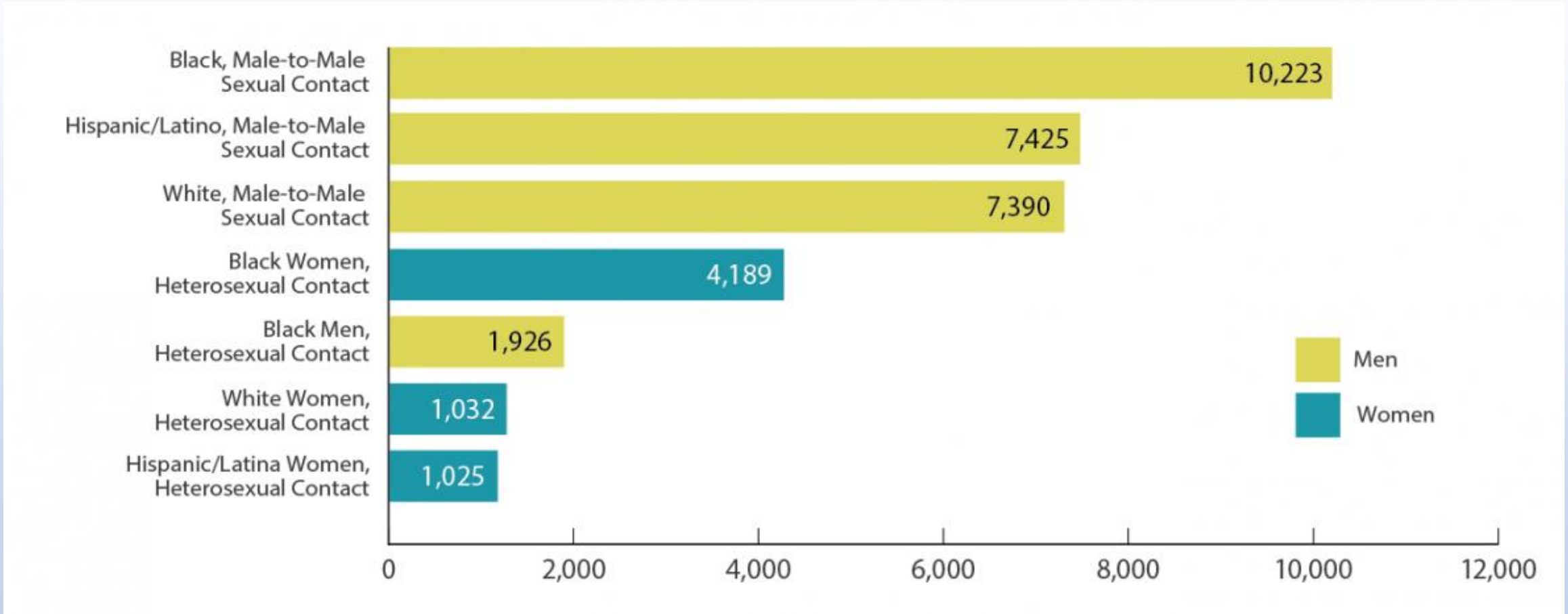
Impacts of Trauma on Health: Structural Violence



Source: Sonia Rastogi, Positive Women's Network

Rates of HIV Transmission

In 2016, 39,782 people received an HIV diagnosis. Note: The CDC excludes trans/intersex from estimates.



Source: CDC. (2017). [Diagnoses of HIV infection in the United States and dependent areas, 2016](#). *HIV Surveillance Report*, 28.

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.***

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 (Machtinger 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, & Venable, 2008).
- Trans women experience high rates of physical (57%) and sexual assault (47%) (Edelman et al., 2015).
- American women living with HIV suffer intimate partner violence at a rate of 55.3% (more than twice the national rate) (Kaiser Family Foundation, 2014).

Transgender Population, HIV, and Trauma

- 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.
- Transgender women are disproportionately the victims of hate violence (National Coalition of Anti-Violence Programs).
- 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 & Cahill, 2018).

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.

Trauma and Risk Behaviors Among PLHIV

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

How Trauma Affects Engagement in HIV Care

Studies indicate that PLHIV 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).

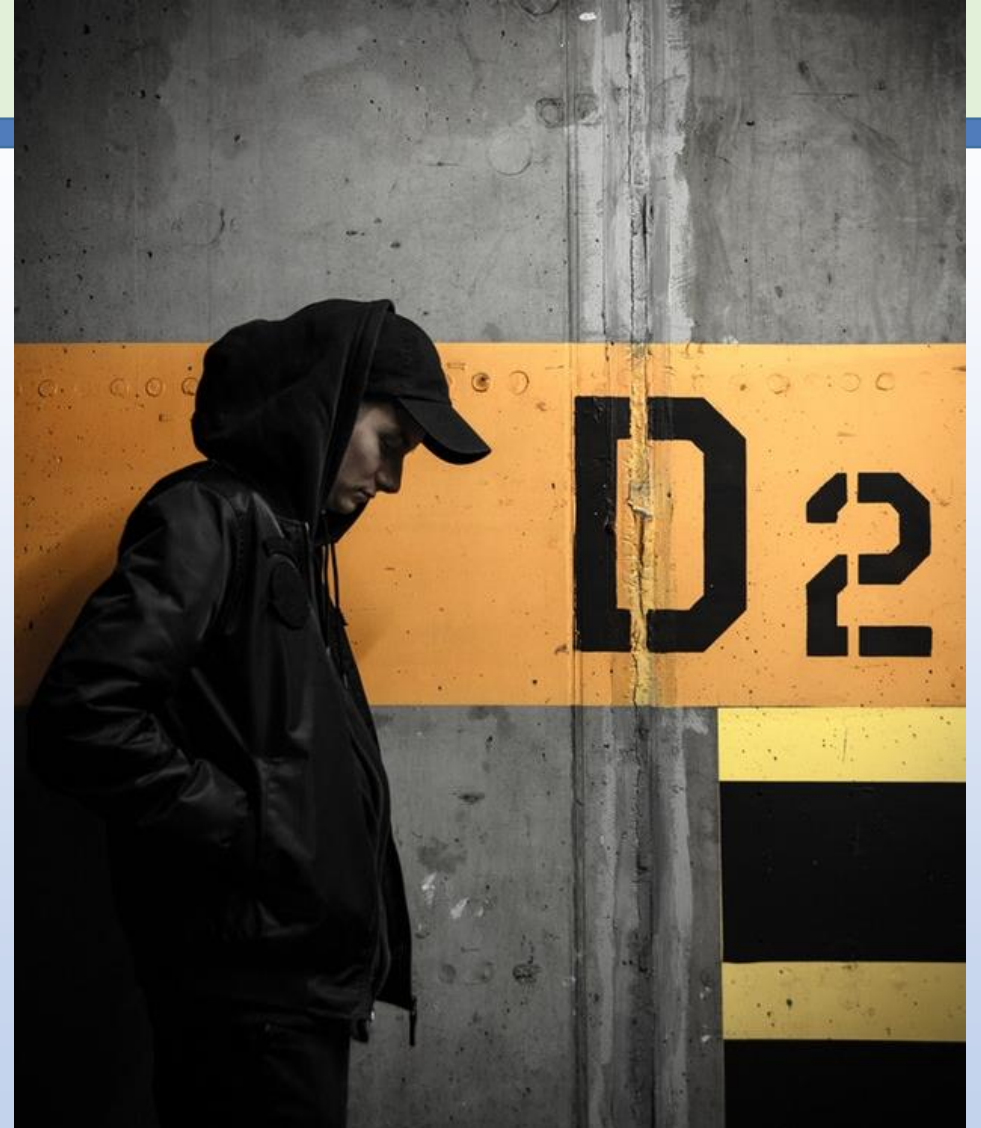


Trauma and Antiretroviral Adherence

- Poor adherence to ART 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 HIV treatment failure.

Trauma and HIV Mortality

Traumatic experiences over the life span are associated with faster development of an opportunistic infection or AIDS-related death (Leserman, 2007).



The Role of the Trauma-informed Service Provider

Need to understand:

- The impact of trauma on the lives of people living with HIV and any co-occurring behavioral health conditions.
- The impact of trauma and prior negative experiences in health care on PLHIV's ability to trust care providers.
- That living with HIV may increase a person's sense of isolation, stress, fears, shame, and internalized stigma.
- The prevalence of ongoing trauma in the lives of PLHIV (intimate partner violence, workplace or community violence).
- The impact of trauma on one's ability to engage in treatment/adherence and to self-manage HIV and other chronic conditions.
- The impact of structural factors such as racism, homophobia, and transphobia in the lives of PLHIV.

Section 3: Summary of Key Points

- Trauma is very widespread in the lives of PLHIV.
- Violence and other forms of trauma further influence health and well-being.
- Trauma affects the ability to effectively link to and engage in care.
- It's important to go beyond a focus on viral suppression to addressing the impact of trauma.



Section 4: Trauma-informed Approaches

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**

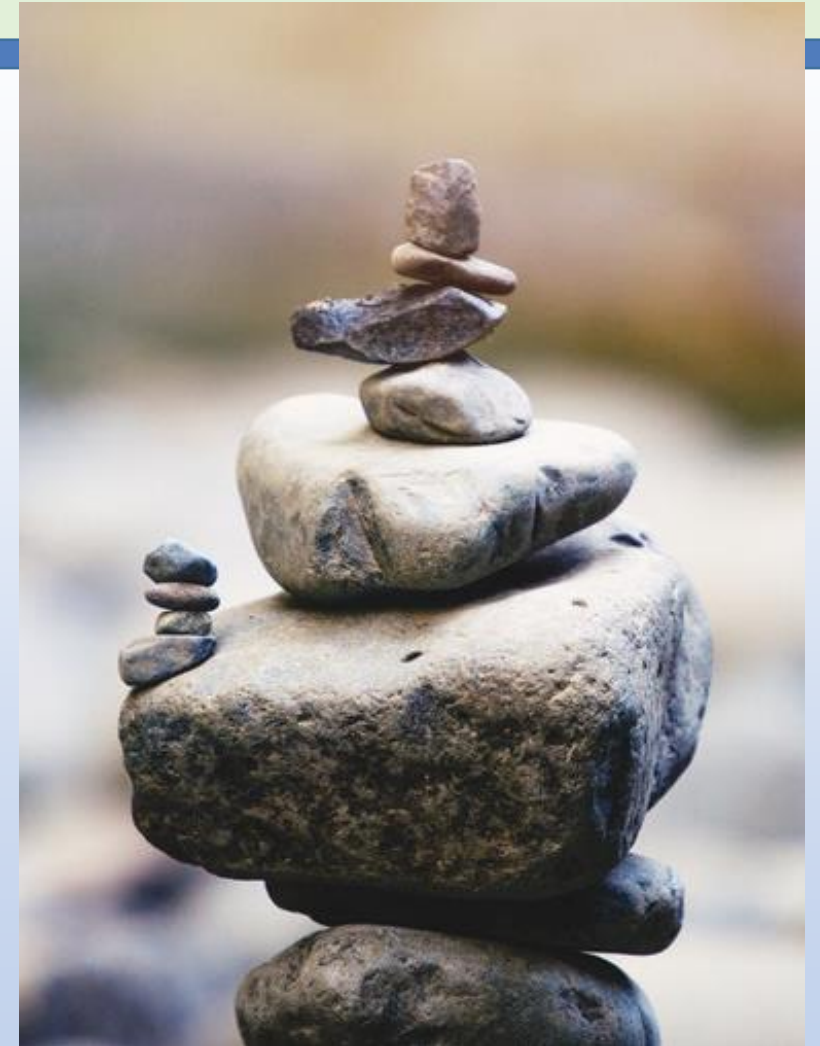
- Seeks to actively *resist* re-traumatization

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*

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



Principle 1: Safety

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

Video suggestion: Cassandra's Story

<https://youtu.be/GYqsSqT1hAA>



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.

“Signs” of Safety and Respect



Interpersonal Communication

- Interpersonal interactions should promote a sense of safety.
- **What are some ways you ensure interactions that promote a sense of safety?**



Reflection Points

- Do staff feel safe in your organization?
 - Why or why not?
- Do the people served feel safe?
 - How do you know?
- What changes could be made to address safety concerns?



Principle 2: Trustworthiness and Transparency

Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among clients, family members, staff, and others involved with the organization.

Examples of Trustworthiness

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



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?

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.



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



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 behavioral health 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.

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

Creating a Healing Organizational Culture

“Having peer support workers on our team makes a difference in the culture. We work with people who are the most in need—people newly released from jail or prison, at-risk youth, folks with dual diagnoses. It can be intense and emotionally challenging work. As a result of the openness of the peers on our team in sharing their experiences, it’s not surprising or shocking when people are in tears. The culture of the agency is accepting of these feelings among staff. Peer workers have also encouraged the broader staff to adopt self-care practices such as mindfulness and yoga.”

—Shaleya Floyd, Clinical Social Worker at the CORE Center

Peer-based Support: Common Threads

Common Threads is:

- A small-group, peer-led HIV training organized around intensive, interactive, skill-building sessions
- Designed to enhance the ability of women living with HIV to understand and share life experiences, including HIV and trauma



Reflection Points

- Does your organization offer access to peer support for the people who use your services? *If so, how?*
- Does your organization offer peer support for staff?
- What barriers are there to implementing peer support in your organization?

Principle 4: Collaboration and Mutuality

- Partnering and leveling of power differences between staff and clients and among organizational staff from direct care to administrators
- Demonstrates 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*

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

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?

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.

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.

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?

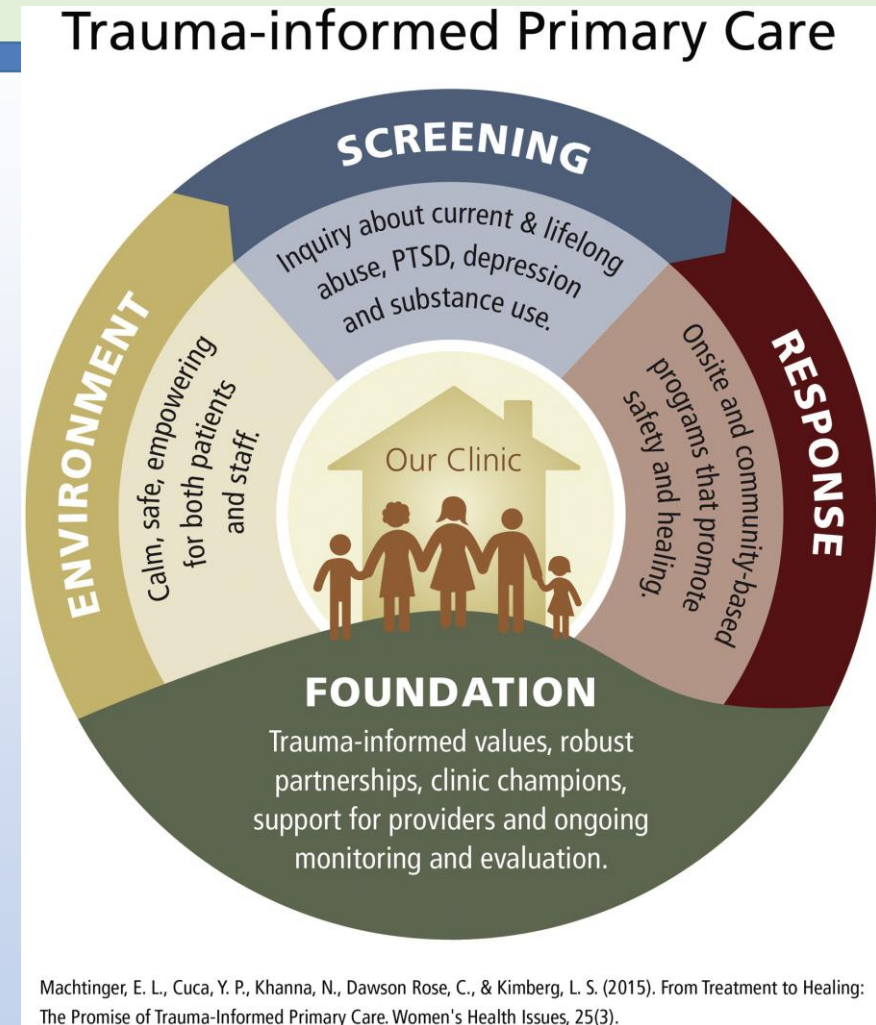
Principle 6: Cultural, Historical, and Gender Issues

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.



Trauma-informed Primary Care Model

UCSF Women's HIV Clinic



Reflection Points

- How does your program demonstrate and invest in training about cultural responsiveness?
- Is your program gender responsive?
 - In what ways?
- Does your staff understand and recognize the possible impact of structural violence or historical trauma?

Trauma-informed Care for PLHIV

Trauma-informed approaches should incorporate the following (Brezing and Freudenreich, 2015):

- A trauma-sensitive practice environment
 - Trainings to ensure a sense of safety in all patient interactions with staff members, including physicians, clinical staff, and administrative staff.
- Identification of trauma and its mediators
 - Sequelae of posttraumatic stress, including poor adherence to treatment and high-risk behaviors.
- Education for PLHIV about the connection between trauma and its negative behavioral and physical health outcomes
- Link PLHIV with suitable resources and referrals for more specialized support as needed

Section 4: Summary of Key Points

- The four Rs of a trauma-informed approach
- SAMHSA's six key principles:
 - Safety
 - Trustworthiness and transparency
 - Peer support
 - Collaboration and mutuality
 - Empowerment, voice, and choice
 - Cultural, historical, and gender issues
- The 4 Cs of working with people who have experienced lifetime trauma



Section 5: Healing & Recovery

Learning Objectives

- Think about what you and your organization can do differently to enable healing.
- Examine how to have the conversation and offer opportunities for trauma healing, even in a brief time frame

Healing is Possible!

“Healing from trauma, like healing from a physical injury, is a natural human process.”

—Richard Mollica



Promoting Healing and Well-being

- People often use the terms “healing” or “wellness” instead of “recovery” when talking about trauma and HIV, but the basic message is the same:
 - *Everyone has the possibility of living a satisfying and meaningful life, regardless of what happened to them or what health challenges they are living with.*
- Remember: Healing happens in relationships.

The 4 Cs: Promoting Healing in Relationships

1. Calm
2. Contain
3. Care
4. Cope

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

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CALM

Center yourself to help model and promote calmness for the person you are working with (co-regulation).

Source: Dr. Leigh Kimberg



Grounding: 90-second Sanity Pit Stop

- *First 30 seconds:* Focus on your breathing. Try to make your in-breath longer than your out-breath.
- *Second 30 seconds:* Connect with your body. Notice areas of tension (face, shoulders, chest, eye muscles) and invite them to relax.
- *Third 30 seconds:* Silently repeat a positive and encouraging message to yourself. (“I love you, keep going,” or “You’ve got this.”)

CALM

- *Assume* trauma could be the root cause of her challenges in adhering to care and alcohol use as a coping mechanism
- *Expect* that change may not happen quickly
- Sample goals:
 - Model a respectful, healthy relationship
 - Prioritize safety and trustworthiness
 - Destigmatize coping behaviors such as substance use
 - Collaborate—take a harm-reduction approach
 - Focus on strengths and resilience
 - Practice with cultural humility and sensitivity to power dynamics

Source: Adapted from Dr. Leigh Kimberg

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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

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

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.

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?”

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

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...
- “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.”

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

CONTAIN (cont.)

- **Ms. Jones becomes upset, tearful, or distressed:**
- **CONTAIN:** “I am hoping that we will gradually get to know each other over time. I’d like to help make this clinic a place that feels healing to you. So it’s very important that we only discuss the amount of detail that will allow you to feel as calm as possible when you leave the appointment. Would you like a referral to a counselor who specializes in helping people heal?”
- **CALM:** Ask if they would like to practice a brief grounding exercise.

Source: Dr. Leigh Kimberg

CARE

- Emphasize good self-care and compassion for both yourself and the patient.
- De-stigmatize harmful behaviors...
 - NOT “*What’s wrong with you?*”
 - Instead, “*What happened to you?*”
- Guilt and shame are common—create nonjudgmental space in which all feelings are valid.
- Distinguish *feelings* (never wrong, often conflicting) from *exploring* (without criticism or judgment) whether a relationship/behavior is harmful.

CARE

- 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.**”

Source: Dr. Leigh Kimberg

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.”

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?”

Source: Dr. Leigh Kimberg

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

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?

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

“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



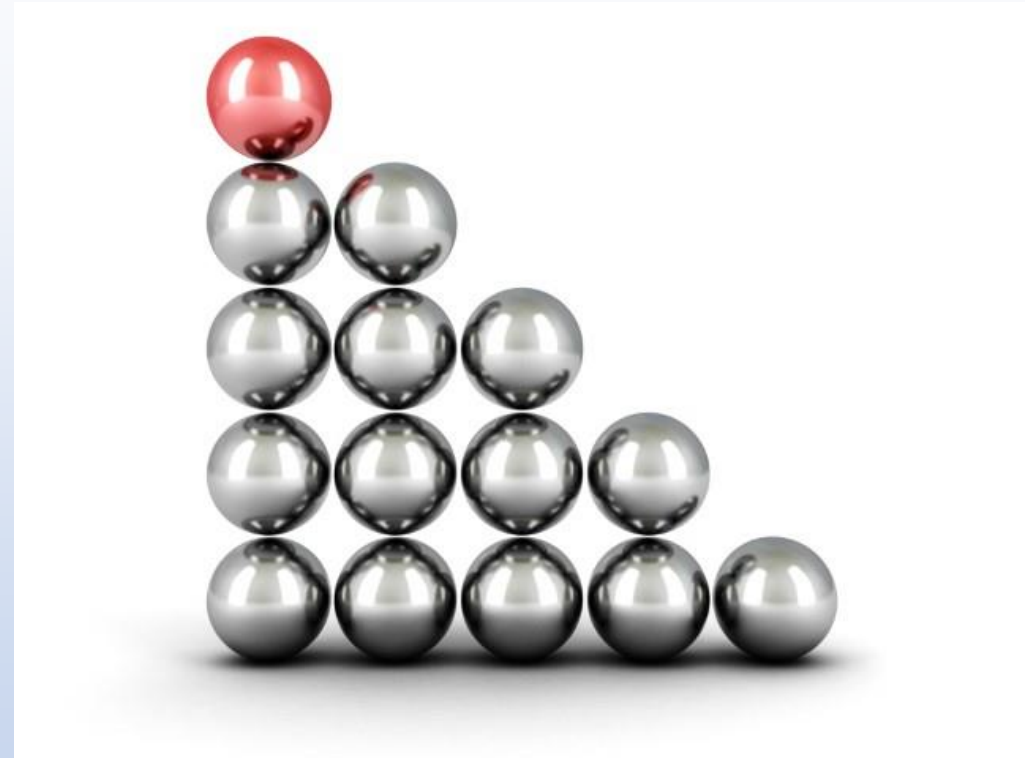
Section 6: SAMHSA's Guidance for Implementation

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.

Interventions

Think of the six SAMHSA principles as *goals* and the 10 SAMHSA domains as the *interventions* or ways you will achieve your goals.



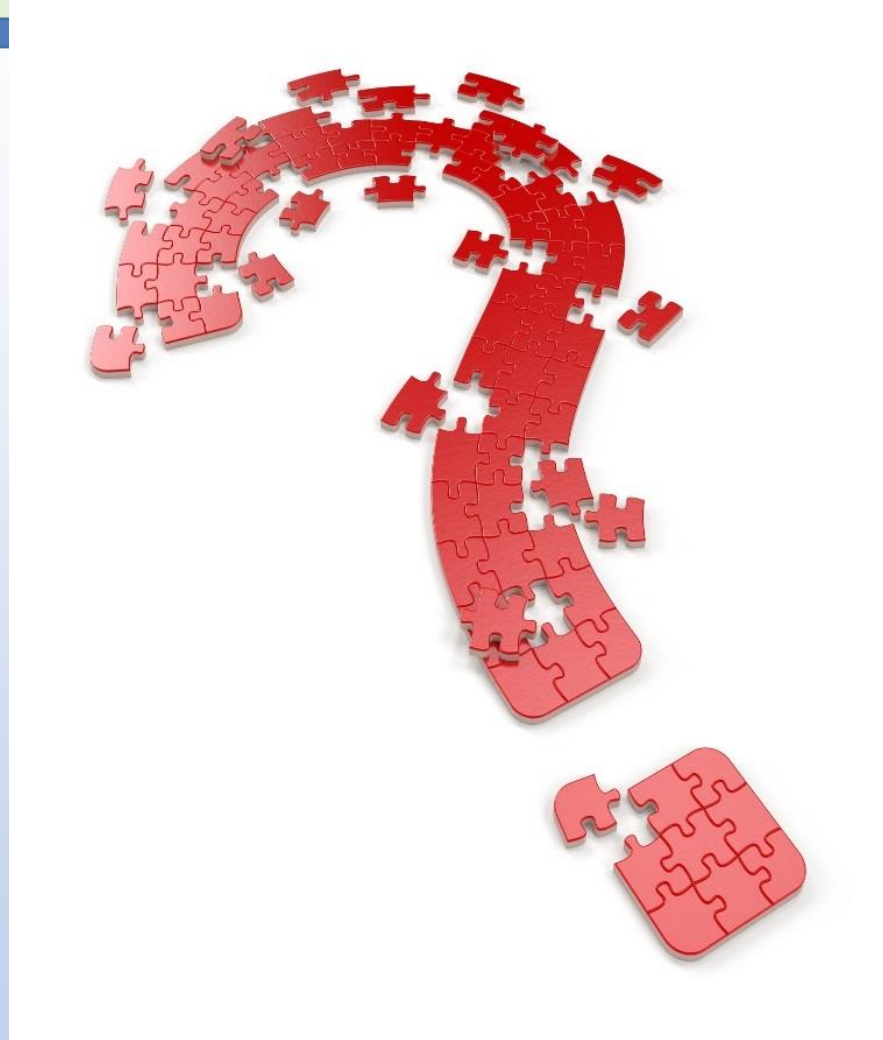
SAMHSA's 10 Domains

1. Governance and leadership
2. Policies and procedures
3. Physical environment
4. Engagement and involvement
5. Cross-sector collaboration
6. Screening, assessment, and treatment
7. Training and workforce development
8. Progress monitoring and quality assurance
9. Financing
10. Evaluation

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.

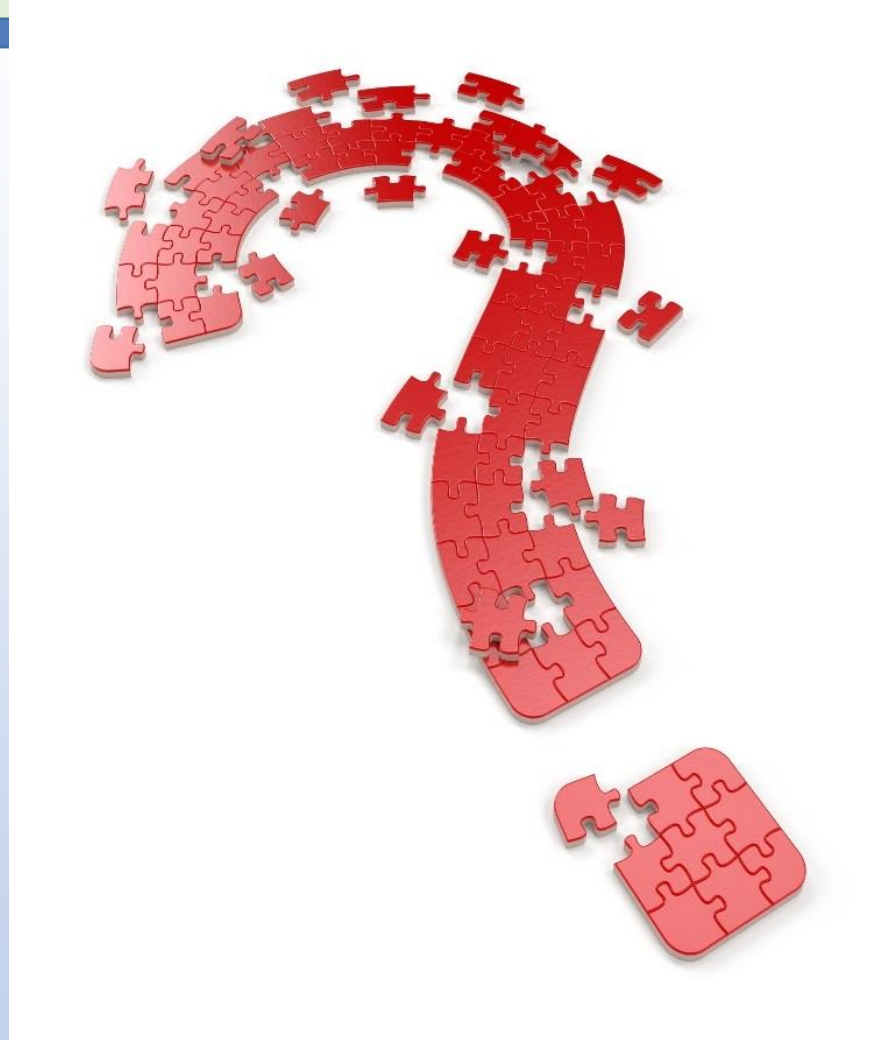
Reflection Point



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.

Reflection Point



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.

Example

*****ALL VISITING PETS MUST BE REGISTERED WITH THE THERAPEUTIC RECREATION DEPT. AND WEAR AN ID**

Western Maryland Hospital Center
Hagerstown, MD 21742

Record of Visiting Pets

DATE	TIME IN	TIME OUT	NAME OF PET	NAME OF PERSON RESPONSIBLE FOR PET	NAME OF R PET
7/18/13	1:50				
7/22/13	1:40		Milton	Tom Rock	Chris
7-26	10:50	11:30	Milton	Tom Rock	Chris
29	10:40	12:25	MILTON	Tom Rock	Chris
8-3	9:15	11:00	Duffy	Christi Hull	Stella
8-4	5:30	4:00	Maddie	Barb Gooden	Sheila
-15	9:00	11:00	Zoe	Julia Godlove	Molly W
-15	10:45	12:30	MILTON	Tom Rock	Chris
-17	12:00	7:00 pm			
-18					
12/22	10:07	7:00 pm	Harley	Darlene Strasser	Wanda
12/23					
12/28	11:10	12:40	MILTON	Tom Rock	Chris
12/29	11:10				
1/4	10:50	12:25	MILTON	Tom Rock	Chris

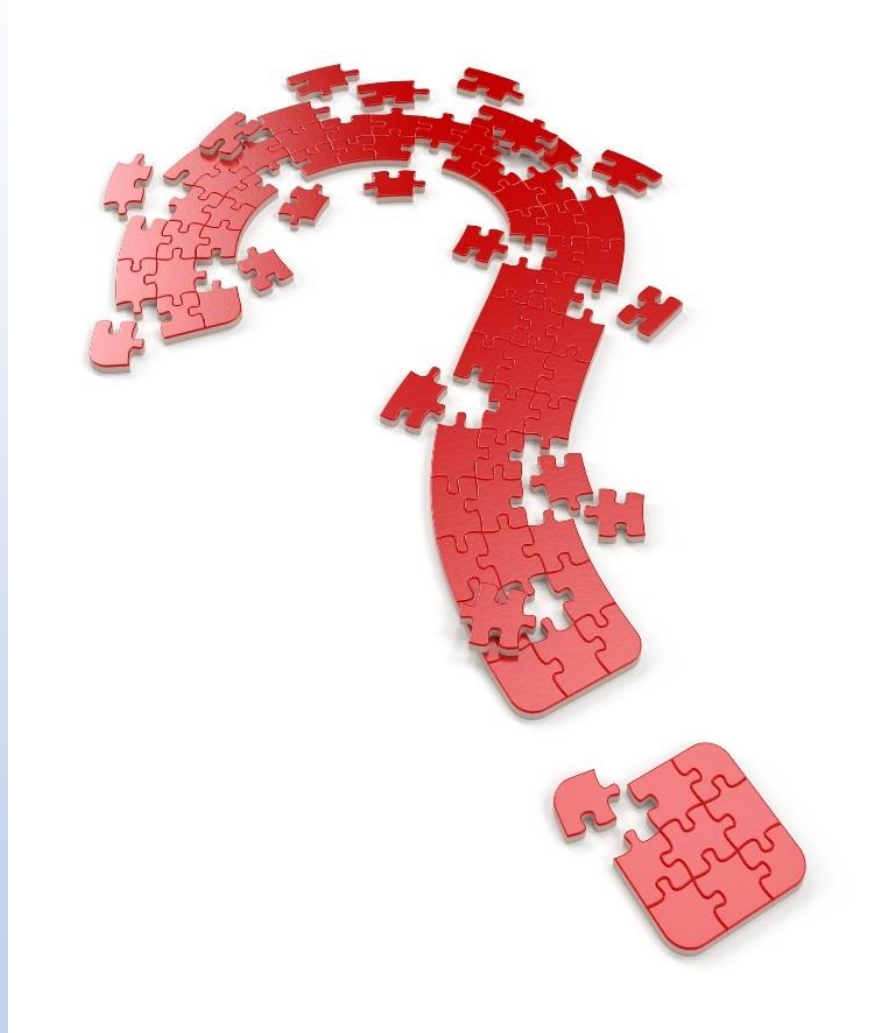
Reflection Point



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.

Reflection Point



Domain 5: Cross-sector Collaboration

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

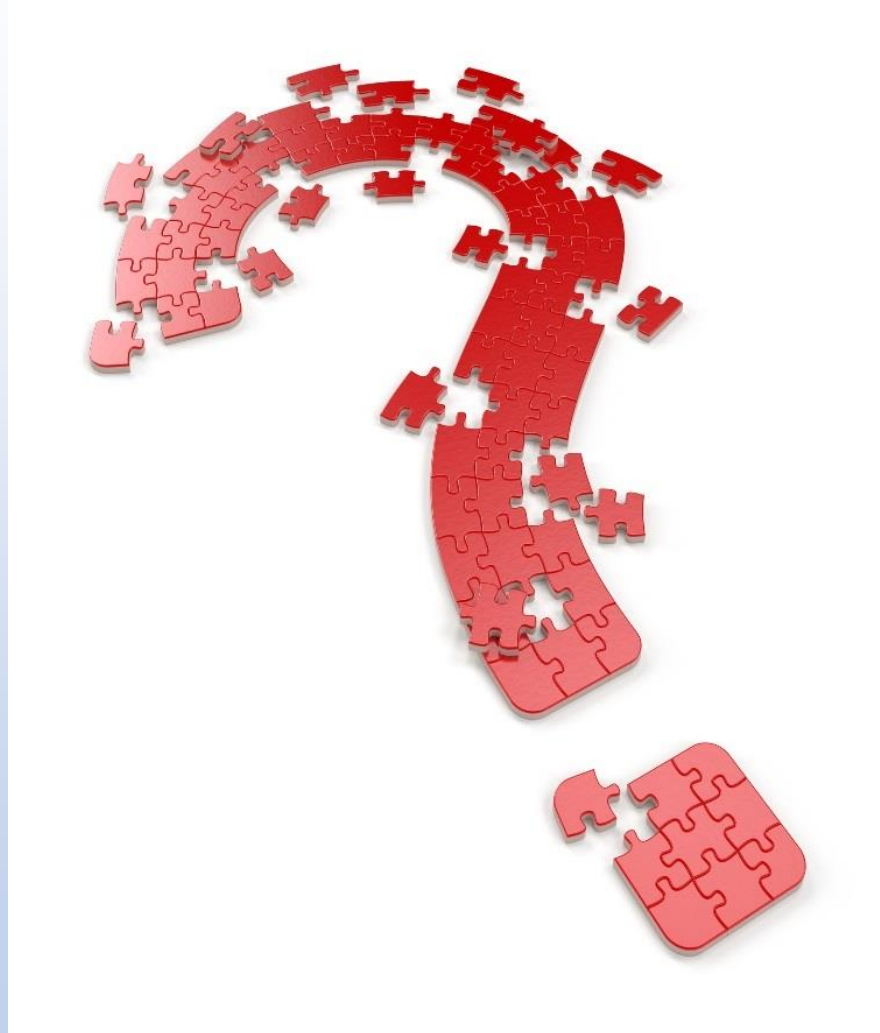
Reflection Point



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

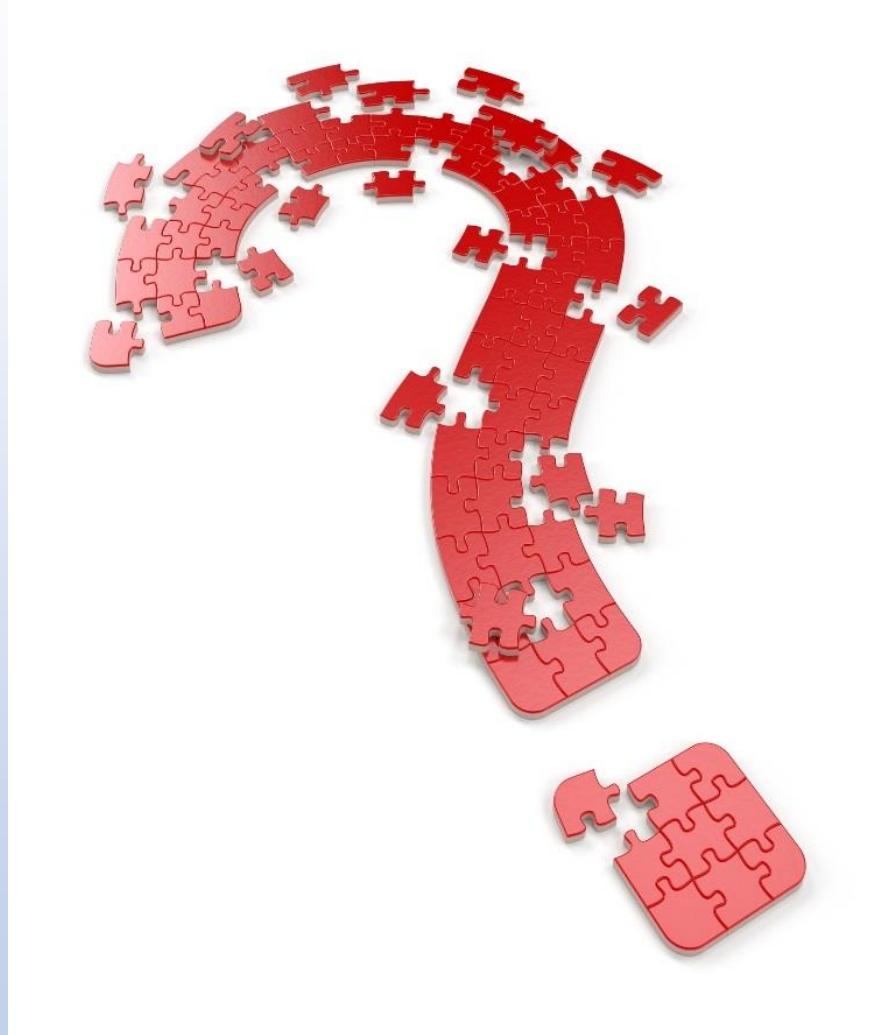
Reflection Point



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.

Reflection Point



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.

Reflection Point



Domain 9: Financing

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

Reflection Point



Domain 10: Evaluation

The measures and evaluation designs used to evaluate service or program implementation and effectiveness reflect an understanding of trauma and appropriate trauma-oriented research instruments.

Reflection Point



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?

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.

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?



THANK YOU!