Clinical Education Initiative
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TRAUMA-INFORMED CARE: THROUGH THE LENS OF HIV

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[video transcript]

Mary retired recently as trainer and research manager at the northeast Caribbean addiction treatment and Transfer Center in New York, at the New York state psychiatric institute. And she's still working as a consultant. She brings 25 years of experience in direct services. And as a trainer. Her areas of expertise include HIV, substance use mental health, trauma, informed care and vocational rehabilitation. She taught at NYU as an adjunct assistant professor in the rehabilitation counseling department, the course on substance use and vocational rehabilitation. She is trained nationwide working with the New York State AIDS Institute, the National Association of drug abuse problems, Oasis, Office of addiction services and supports, and the US Peace Corps. She has developed training curriculum that promotes evidence-based practices. She has a BA in English from the State University of New York at Albany, and an MA from New York University and rehabilitation counseling. Thank you, Mary, for joining us today. And I'll now turn it over to you.

01:16
Thank you, I always like wave. Thank you, Phoebe, for asking me to present. It's always an honor to present for CEI. And so I am happy to be here, I can't see who you are. But I heard there's lots of clinicians throughout New York State. So I'm not going to do one of those go arounds, obviously, because this is an hour presentation. But I was a rehab counselor by trade. But I always tell people, I come from a family of nurses. And when I was showing my sister, one of the nurses, this information on trauma informed care, she's like, Mary, that's what we learned in nursing school. That's what we do all the time. So sometimes you go to a training, and it kind of educates your instincts. Other times, hopefully, you'll learn something. But again, thank you for coming here. Let's see, I don't have any financial relationships with any companies. So here's what we're going to do today. This, by the way, is a very basic course. You know, in the old days, pre COVID, when we used to do trainings for three to six hours, we could take this kind of information and delve into it. So here's what we're going to do, we'll look at defining trauma, the effects of trauma on the body, and trauma informed care. That's kind of the basis of the course, we'll also look at the scope and impact of trauma for persons living with HIV. And I think one of the things that as I was kind of repairing for the course, is to look at all of this information on trauma in terms of people with HIV, HIV. And so sometimes this is stuff that you already know. But I think it's important to look at the look at resiliency and risk factors of trauma for people living with HIV. And we'll look at some evidence based practices to mitigate trauma. Here's the good news about trauma, not the good news. But people heal from trauma there,

you know, you'll hear those expressions heal people heal, actually, they also say Hurt people hurt. So that might affect when somebody's like mean to you or they're giving you a hard time. Sometimes it's the effects of the of their trauma on their behavior. But with the right, the correct practices or interventions. It works is it simple, no easy for me to say as I'm sitting here in my office at home, because sometimes, you know, you're working with people who have such extreme levels of trauma. But the good news is that with the proper help, they can get better. So if you want to do this course, by the way, used to be some of you may be familiar with the tips if you worked in substance abuse, treatment improvement protocols. They were free books that you got from the government, from substance abuse from SAMSA, Substance Abuse and Mental Health Services. And I don't think they send out the books that much anymore, but you can. You can download them and it's a way to get really free, actually up to date information. Another thing too, and I don't know if there's anybody out there from Buffalo but the SUNY Buffalo the School of Social Work is really a leader in trauma informed care and I have used their slides I've put their names Were the slides where I borrowed, but they also will do. And they're still doing this, because I just checked on their website, if you want your agency to have a project of really looking at your whole agency from a trauma informed care point of view, they can do it and they do it for free. So, when you look at, for example, you know, trauma and HIV, like, what's the connection, and some of this may seem, like I said, things, things that, you know, a couple of things I'll start with saying is, the difficulty with HIV as the incidence with mental health and substance use is they are disabilities that have high stigma to begin with. So and if you look, for example, it may be the stigma in some families of being gay, that is also something that people take in. And so when you hear about the stigma, or you feel the stigma, and then you have other traumas, it really just makes it makes the other traumas worse. I used to say, for example, nobody comes up to you with HIV and substance abuse and mental health, people blame you for getting them. Nobody goes up to somebody in a wheelchair and says, Come on, get out of there, you know, start walking, what's wrong with you, you must not be voted in. So no, that's a gross example. But, but it's just sometimes looks at what we expect, or some of the things that that we look at. So here's what we know. This, by the way, some of it comes from the City University, there was a researcher named Kevin Nadal, and he's done a lot of work with LGBTQ people. And it's people living with HIV experienced disproportionately high rates of trauma throughout the span. Again, no, no surprise, trauma experiences are far more common among people living with HIV than in the general US population. I will say that, and this is what sometimes the National Center for trauma talks about is assume that everybody who comes to see you has experienced trauma. And that's you as well, by the way, they say that 99% of people have experienced trauma. There are big traumas, and they're little traumas, but it's important to realize that when people come to you, they may have the odds are they have experienced trauma. People living with HIV are also disproportionately affected by adult trauma, including

the inter intimate partner violence, which is someone's call domestic violence or has been, it's been kind of changed to intimate partner violence to make it kind of clear. And what happens sometimes to let's say, with, with same sex couples, is people don't always take their intimate partner violence that seriously. So the police come and they see two guys fighting, they're like, You know what, or one guy is fighting and one guy is not there, they have a certain view about it, a skewed view about it, or if two women are fighting, they'll also kind of look at that a scant. And so what happens to is that lifetime trauma impacts both HIV risk and the ability of people living with HIV to engage in care. So for people not coming to treatment. So what is trauma? This is one of those strawberry drinks, by the way, so it looks like I'm drinking something weird. It kind of is. But so tip, tip 57. When they were doing working with trauma, they looked, they broke it down into three E's. And here's what they said it was. So the first E is for events and circumstances. So in trauma, by the way, kind of the definition is experiences that cause intense psychological and physical reactions. So the events can be single, or a series so sometimes somebody's dealing with sexual assault. Sometimes many of your clients have dealt with a long series of sexual abuse. The E is the second is the individuals experience with that and sometimes it's they'll determine whether it was traumatic or not. So sometimes you can have two people experienced the same thing. One person thinks it's traumatic and the other doesn't. So it's kind of a judgment call. And one of the things we look at too is the long lasting adverse effects So do people get Post Traumatic Stress Disorder? Sometimes is everybody get it? No. I think on this next one, this is just an example. And oh, no, it just says what I what I what I just said. But it speaks to again, about everyone is different. We'll look at resiliency factors, because sometimes you can have two people with the same having experienced the same thing. And one person gets through it and the other doesn't. And when they look at, for example, you know, what made them feel from it so quickly, or get back to quote, normal so quickly, that it's often

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social supports different kinds of resiliency factors that the person has, that helps them deal with things. It's and it's funny, because every time I'm doing this course, there's always events like the one in Maui, or the one in Morocco or Libya. And so sometimes you kind of look at it and go, I can't make this too simplistic. You know, will people be affected for a long time? You know, I, I don't I don't know the answer to that, because I'm not experiencing it. But it just one of those ICS a trainer answer. It depends. Now, what I'm going to do is I'm actually going to go to the next slide, and I'm just going to say, there's different kinds of traumas, by the way, and sometimes they fit into categories like natural disasters, accidents, or intentional acts. So I'm going to go back and we don't have any polls today, I'm actually going to ask you to write in if you would like to in the chat. What do you think it's easier to heal from a natural, B accidents, C intentional? D Difficult to say? So if you would, please write in. Okay, I see. Thanks. Thanks,

Angela. I don't always mention people's names, by the way, but you can all see the other everybody's names. Difficult to say C, D, difficult to say a. Thanks for writing him by the way. D we get a lot of deeds and a fair amount of A's.

12:37
But a D is difficult to say.

12:44
I see another D. Okay, you know, I can tell you what the literature says. But then I also can't tell you what I think the answer might be today. The literature says that, quote, natural events, natural traumas are sometimes easier to heal from. And they think that it's because sometimes when there's a natural event, everybody gets together, and everybody helps everybody. And there's a different kind of feelings. And if it is, let's say if it is intentional, but I had a D difficult to say, because I think it depends. So for example, you could have a natural disaster. Remember, a couple of years ago in Puerto Rico, they had a disaster, they had a hurricane or superstorm. And then the government didn't help them. So you had like two things. One, you had the disaster, and then you were getting no help. So what's worse? I don't know. So that's why I think it is it is difficult to say that it's one of those things, you know, as counselors or clinicians, everybody's got a different response and you can ask them for that. So, tell you what the literature says and also for those of you who wrote d I tend to agree with you on that hard to say. So these are just some examples and you can see them of the different ones of natural disasters. Accidents is thinking of accidents like the train derailments, you know, when there's nobody on the on the course, I think for most Ohio, but remember, in the summer, there were a lot of trains that crashed but they had harmful. They had really bad stuff on them. And so the towns that were around that were affected, like everybody had to leave. So sometimes it can be the accident affects the whole Little town where the whole area Yeah, you know what actually for those? Thanks, Gil for answering. I'm not good with hand raising. But if, if you have a question and you take them in, I'm going to spend some time at the end doing them. I find if I answered them too much during the presentation, my timing is really off. And I want to make sure that you get what you need to get out of this. If you look, for example, on the right, right side, the intentional acts, and these are a lot of things that we see, with our clients. I don't if you want to add anything to that, I mean, I can add things to some of the intentional acts of homicide, suicide, domestic violence, school violence, bullying, genocide, go like you've got a lot of stuff in here, physical abuse, or neglect, sexual assault or abuse warfare, you could also add in, for example, food insecurity, homophobia, violence in general, racism, minority trauma, there gonna be a whole things around discrimination. And I think that you're gonna have a whole course on this around, around discrimination. And I'll talk a little bit more about it when I look at some of cultural

responses in terms of cultural responses in terms of trauma informed care, okay. So just, some of you may know this, but just to kind of look at acute versus post-traumatic stress. I didn't pull my I happen to own a DSM five, and what the DSM five, the Diagnostic and Statistical Manual of Mental Disorders, when it came out, they had a separate chapter for trauma, and that was new from the other four were more than four, but from the other, the other ones. And a lot of times the difference between acute and post-traumatic stress is it's about time. So acute really is 30 days or less, post traumatic is after the event, and that the symptoms still say and I'm just going to read some of the things so some people may see with post-traumatic stress, flashbacks, meaning they're having the memory without the distance, or severe nightmares, persistent avoidance, these are all things you can do by you know, you might have a nightmare, you might have persistent avoidance at times, but negative alterations in cognition, not everyone gets a diagnosis of post-traumatic stress, by the way. But it's important actually, if people do have it, that, you know, we, we work, we work with that, just to throw in something about the difference between trauma and women versus men. If you ever Google Stephanie Covington, she's really a super, super bright person. And also she was really nice in person, when I asked her if I could borrow her stuff. She did a lot of work on treatment on substance use treatment for women, because she said, everything's done for men, we need to look at women. And what they found is that both women and men have high levels of stress. But you know, what the difference is that men, usually when they're dealing with a traumatic event, it's somebody they don't know. Whereas with women, it's people they do, they do know. So you know, when you think for example, of somebody dealing with sexual abuse as a child, it could be a father could be an uncle could be a mother. So it could be a variety of, of things around stress, post-traumatic stress. So and this is something that many of our, or people have, too, is complex trauma. And it just really what it speaks to, again, is that sometimes people have traumas at the beginning of their, you know, their three, and they don't have enough food to eat or they're getting verbally abused at a young age, then they go to school and they get bullied. Then they go to high school and they get into relationships where they are beaten up. So there's a whole series of things. And one of the things that happen with complex trauma is that many of our people have multiple traumas. But if they're not integrated, there's no such thing as an immunity to trauma. I know this. There's this thing that says, What doesn't kill you makes you stronger? I'm not sure I totally believe that, the more the more people have, or the more traumas a person has, the less the there is an immunity to it. So somebody could have had five traumas, and then you meet them, and they have the sticks. And then they react in ways that you think, Oh, that's not. So I don't know what's so dramatic about that. But again, we don't develop an immunity to it. I think that's an important one of the examples, and one could talk about this, but just put the put this in for a couple of reasons. One, in case I forgot some of the examples, but Tom grew up in a family that did not accept people who were gay. So for example, many people grow up in areas

where it's not acceptable to be gay. And so they hear that a lot, or they go to a church that says, You're gonna go to hell. Because you prefer you like, prefer, that's a bad word. Because you'd like people. Sorry, let me go back. People here, when they go to church, that if they are gay, they will go to hell. And if you hear that all the time, or you hear it in your family, how does that trauma affect the person. And again, the example I gave was, for many people who've been bullied. And one of the reasons I put this thing about not getting into treatment for HIV in its community, I was doing a training in Brooklyn once and there were a lot of young men working at this agency. And when we talked about where they went for treatment, they refuse to go to treatment in their neighborhood, because they didn't want people to see them going into an LGBTQ or an HIV kind of agency. So they would sometimes go to a bigger hospital in the borough, again, in Brooklyn, they were going to Kings County. Sometimes, though, people said that they were afraid to get on the subway. So that for example, sometimes people as somebody was telling me that they lived in the Bronx, they didn't want to come into Manhattan by subway, and they were transgender. They didn't want to get on the subway because they're afraid that we're going to get beat up. So all of that trauma, I think is important to kind of keep in mind the amount of trauma alright.

22:41
So, the ACE study in a STEM K stands for adverse childhood experiences, looks at what happens to a person before the age of 18. This didn't come from this slide came from SUNY Buffalo. And just some of the history of how this came about is super to researchers. And, and Felitti in and they did it in 1995, like, interested in why she is bringing this up in 1995. But they asked 17,000 participants, you know, what was going on in their lives. And this is what they came, they came up with, um, prior to that they were working with people who were obese, and this was before bariatric surgery. And they had two women who were sisters. And they both lost like 80 pounds. And once they stopped treatment, they gained 80 pounds back there, like, hey, what happened? Why did this happen? And what they found out was both sisters, were being sexually abused by their father. So see, it's again, not a surprise. If you ever watch that show my 600 pound life on TLC I have to admit, I watched that show. I didn't I used to watch that show a lot. I don't so much anymore. But a almost everybody who's on that show is was sexually abused as a child. So TLC my, like my junk food candy. It's like junk food TV. Alright, so here's what they broke it down into abuse, neglect and household dysfunction. So you can see abuse, physical abuse, emotional abuse, sexual abuse, neglect, and people so much forget about neglect, like physical neglect, like people, parents disappearing for a long time the kids are left by themselves. And also emotional neglect, so not giving a child what they need. They also looked at household dysfunction, mental illness, incarcerated family member mother treated violently, substance abuse, divorce, and they found that the more you said yes to I'm gonna wait sorry. When to go

back, the more that the higher your ACE score, the higher the correlation between certain illnesses, which will be on a further slide. And one of the things to keep in mind is that is, is that, you know, I went to training once, that's definitely Covington did. And so she gave out this form. And she asked us all to fill it out for our aces. And it was a drug court conference, he had judges, prosecutors, all kinds of people who work in the criminal justice system. So everybody starts out like, right, and then after a while everybody's like, going like this is they're filling it up. So I learned from that I once did it for a class at one I used to work at National Development and Research Institute and decided never to do that. So not a good place to be now creating safety for people. And that's what trauma informed care is about. So some other aces and this also goes to, actually LGBT people as well as people with living with HIV, poverty, peer victimization, and peer rejection, those are two big, big ones, and exposure to community violence. So we don't want to minimize exposure to community violence, just because you aren't part of that doesn't mean that it doesn't affect you. So there is, this is a quote from Nadine Burke. Harris, she has a really good TED Talk, by the way. And she is a pediatrician, and she's actually the California Surgeon General. And this is what she had said, Imagine you're walking in the forest and you see it there. Your hypothalamus sends a signal to your pituitary, which sends a signal to your adrenal glands that says, release stress hormones, adrenaline, cortisol, so your heart starts to pound, your pupils dilate, your airways open up, and you're ready to either fight that bear or run, you know, and that's wonderful. If you're in a forest, I'm not sure that's wonderful if you're in a forest, but what happens when you go home every day, and you're dealing with that. So that's a common thing. She's actually working with people, with pediatricians to stop some of those, those aces and to prevent them. What they know, by the way, is in some of the correlations, and it's not cause but it's correlations that when people have high ace numbers, high aces, they it affects their physical health, you can see what you see their mental health, behavioral health, and these are all things that often we deal with, with our with our client, it doesn't mean like so for example, somebody starts smoking when they're 13. And then they get lung cancer later on. So is there a quote, good put a cause between smoking and lung cancer, but with the smoking as a result of dealing with some of the traumas? All right. trauma response. So you've, most of you have heard of the terms of flight, freeze, flight, fight or freeze, another one that's not as well-known as spawn, and I'm not going to get it. What here's what I'll explain is that sometimes everybody's got a different way of dealing with stress. So sometimes people fight. And you know, they deal sometimes they come to see you later on, if they're a fighter, they may be experiencing or showing you anger or rage. Sometimes people run. And there is panic or avoid, and sometimes people freeze, and sometimes people shut down as a part of freezing or they feel known. And one of the things about font or fawning is it's common substance use, by the way. And here's what it means displaying exaggerating flattery or affection obsequious, like the word exceed. obsequious. So sometimes, but think, for example, sometimes as a child, it might

have been a survival mechanism, you know, to get through, get through the day or people pleasing, that it results actually in lack of boundaries. And so it's another part of the trauma response. So if you're working in substance use training or treatment, you may see that as well. Alright, some of these I'm going to go over quickly because I see that I've 25 minutes and I've got tons of slides. And I'm not a scientist, but I think one thing the amygdala is the part in the body and the brain that deals, it puts you on high alert. It's where all of the emotions come out. It's part of the limbic system, it's attached to the hippocampus. And that becomes helps you make connections. So for example, you hear a lot of noise outside your window while the training is going on. Your amygdala made me get stress. But your hippocampus is no, that's just a trick, that's just a truck, that's not people, shooting up people, that's not a bomb. So those are things that become less effective, although the treatments actually will help that, I'm going to go over some of the building resiliency and protective factors, because these are things you do with people. And it just in a sense, tells you to like, give yourself credit for these because, and one thing about resilience is adaptive, it doesn't have to be quick, like so for example, we've all gone through COVID. And then you kind of go back to quote, normal, and you're like, Ooh, this is tricky, you know, it's just gonna take me a while. So you don't have to adapt overnight. You can take your time on these. And these are also things you shouldn't do for yourself. As far as like self-care, but so it's like, who's your social support. And these are things you help people deal with, with family support, economic stability, employment, healthy self-esteem, tendency to find meaning, aptitude, and spirituality. So a lot of programs that have spirituality as part of that, I think is an important, important thing to keep in mind. So the more resiliency factors a person has, the better, they are going to be more protected from trauma. Now, the risk factors for trauma, and again, this may describe a lot of people. I was thinking, for example, so about HIV survivors skills, if you've working with a lot of people who are over the age of 50, either living with HIV or gay men over the age of 50, who are HIV negative. There's a fair amount of survivor's guilt, and what's happened to a lot of people in the 70s. As you get older, anyways, your friends die. So sometimes those social supports that you had don't exist anymore. So you could look at some of the risk factors. I'm going to say just take a look at this. And actually, I'm getting to the next slide on trauma informed care, which I think is important part of this. So the more people have, the more they're at risk for trauma.

32:45
All right. So what is trauma informed care? And this I think, is important to look at the trauma informed care really is. It's a it's a systems approach. So you look at your agency, and you assess it from the physical plant, who you hire, what are the hours of operation? Do you have security guards? You know, are there glasses glass, like doors to get to get in? Where are the bathrooms? What are the bathroom with call? So for many people, let's say who are

transgender, when they walk into an agency, they are wondering which bathroom can I go into? And also, will the person call me by the name that I want? So here's, here's a couple of things, I think to keep in mind. I'm going to jump around on this but using universal precautions. So assume that people have experienced trauma. And the two things if I were to break it down to what is trauma informed care is one, how do you create safety for people? How do you create safety for people? And two, how do you avoid retraumatization because sometimes you do it, you re traumatize somebody without thinking about it, or without being aware of it. And sometimes it's not your fault. Sometimes it is your fault. But those are the two big things about trauma informed care. Now, creating safety. You know, remind me to be like after, after cope, or during COVID Many people who had experienced the early AIDS epidemic were triggered by COVID. To go back to some of the times in the early AIDS epidemic, and that was something too. You know, I'm old enough to remember that and people would just people are just dying like people at GMHC every week if you work there, people would go to funerals of staff people of patients It was horrible. Um, but I think the thing with safety is, you always have to make sure you figure out what, what do you do to create safety for yourself, because if you don't feel safe, then that usually kind of be I don't know can affect the help people, you know, people pick up on your own feelings of that. So here's some retraumatization. By, by systems and sometimes when, especially if it's trauma. Sometimes people have to retell the story, what I find is adult a major illness this year, and actually what's been good as people will say, I know you've already been asked these questions before, may I ask you them again? And then I say, Yes, of course. But they kind of acknowledged that I've been asked them like 18 times. But sometimes people get into this, they want to know all the details about the abuse, you don't need to know that and you don't need to have people retell the story over and over and over again, because that is re traumatizing. Also, for some people have been sexually abused, they go to the doctor and you're going for a, an appointment, and they asked you to disrobe for a lot of people that is traumatic. And I've heard, I used to hear that a lot. When I was training a lot of peer workers, were going to a doctor going to a gynecologist was terrifying. And for a lot of people, they you know, we're not giving a choice. Kind of funny story is, my late husband was in the hospital. And the doctor was doing a mental status exam. So she's like yelling the questions. And like, Do you know where you are? And he said to her, please stop yelling. I was like, so like, pleasantly surprised. But so sometimes having a voice that's loud, especially if somebody has been victimized or a victim of domestic violence, or as a kid getting yelled at a lot that can really trigger people. So it's just something to look at how do we look at our systems and not re traumatize people? These are the trauma informed care principles. I will review them quickly because I want to make sure that you have time for some questions is that we'll look at safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and empowerment and choice and cultural responsive Ness. So I'm going to talk fast like a New

Yorker. So safety, here's what you want to do eliminate shame. Sometimes somebody comes in, and they tell you something, and in your mind, you're gone. What was he thinking? Why was he doing that? But you want to be really clear on? It's always important I used to teach at NYU is deaf people get in touch with your own stuff? You know, when they tell you at the beginning about implicit bias? What are your implicit biases because they're going to come out? And it always surprised me, I remember, I would do a training and somebody said, I don't like working with gay people. And the weird part was, she was a volunteer at GMHC, a Gay Men's Health Crisis. I was like, What happened to that? scary to me, terrifying to me, this was a long time ago, by the way. So if you work for GMHC, I don't hope hopefully, they don't do that anymore. But you don't want to create people come in with shame. You don't want to make it worse. It's funny, I worked at a place at a Korea for a year and there were a lot of actually young, young gay men. And I thought, gosh, they're never going to talk to me, you know, and I was surprised that they shared with me a lot of information. And so I said to another woman, surprise, they're like, telling me all this stuff. And they said, you know why? Because you're not related to them. And they know you're not gonna go tell her mother. So they feel a certain sense of safety because there's a certain distance with that. All right. trustworthiness and transparency, it's really, you know, counseling one on one, it's about being authentic. And some of the examples are yes, a person to meet you at 10. And you show up on time. I did this in New Jersey once and a lot of the counselors go no, we can't be at if we were always late. And I think the commissioner was there and she said, Listen, this is what you need to know. When people call my office they call because you were late or you weren't, you didn't show up. So I think that it's important to look at it doesn't you know, sometimes you can't always be on time, but always to apologize and to be real about it. Other things for example, are collaboration. And mutuality is like working with other systems. We used to sometimes, you know, Oasis used to have this thing where they would kind of acknowledge, quote, gay friendly treatment. And I used to call a lot of the places or ask people for advice of what their experiences were. And you know what, just because they checked off the box didn't mean it was true. So sometimes people would be going into treatment. And they knew that the place was not gay friendly, but we wanted to let people know, this place is not gay friendly, you may want to go to another place. And somebody said to me, no, I don't really I'm not too concerned about that they're good at substance use, and that's what I need. So you just always want to kind of look at that. How to how do you how do you hear support? How do you communicate with people? Remember pre COVID, it was just that lessons who are texting, and now everybody texts, but I think it's important to a lot of my friends who are therapists had to learn how to do therapy on Zoom. And they said now that they first it was terrifying. And now they've learned how to do it. So that's a good thing. But what's the best way to communicate with somebody? And the famous question, did you ever text a purse? Do you ever text a message to the wrong person, so you want to be kind of clear on that?

Empowerment and choice, again, listening to people, encouraging clients to speak up, many clients have not had a voice or choice. And so they've been victims of domestic violence or come from families where they had no choice of giving people choices important. Now, cultural responsiveness. I think you could do a whole course on that. And what I'll say about that is, and you can look at intersectionality is that many people come to us, kind of

42:04
they actually straddle many different cultural, oppressed cultures, whether it's on sexual orientation, gender identity, poverty, racism class. So you just want to be aware of that and build on cultural strength. You want to look at what are the healing rituals within a culture. So Lakota, Lakota had been using dance as a healing ritual. And also, there was a drug court in New Mexico that when people graduated, they inclusion drumming as part of their graduation. So how do you look at and Portland State, by the way, in the state of Oregon, also does a lot of really good, good stuff are around that. Now, trauma specific trauma informed so trauma informed is the intervention. Trauma specific is there are people who are qualified and trained to deal with their specialists in trauma. And I think that's important. Remember, the whole thing about do no harm, you don't want to be sometimes to do sometimes the client feels comfortable with you. And they tell you a lot of stuff about their traumas. And you need to validate them, you need to believe them. And but again, to make a referral, and it was in a training recently, where somebody was talking about all the training they went through on trauma like so if you're making a referral to somebody who's traumas Pacific, ask them how long they've been doing the work, what kind of training did they have? What's their specialty? Because I think that's important, as well. My favorite ones stay in your lane. And, again, I'll just go over these quickly. But because I want to, again, open it up to questions. These are some of the evidence based practices that exists. And the good thing about evidence based practices as we know, they work and so there's cognitive behavioral therapy, so cognitive behavioral deals with thoughts and feelings. There's something that actually the government put out SAMSA put out called gay CBT. And it's manualized. So I don't know if you can still get it for free. But with CBT is usually if somebody's doing a group, there's a manual, it tells you exactly what to do. And in this particular intervention, all the examples are from people, generally from people who are LGBTQ people. So that's important. Another common one is EMDR Eye Movement Desensitization and Reprocessing was a common one that was used. Why am I going like this? Because what it does is the therapist will have you move your eyes until this Story is a common one used after 911. It's covered by insurance, it's short term. And that one, again, find out at your place who is a, an EMDR, specialist exposure therapy. A lot of these were developed as a result of the Iraq and Afghanistan wars. You need to know what you're doing with that, because you don't want to. You don't want to harm people. And there's different group interventions like seeking safety,

which was developed to work with people who are dealing with substance use and with domestic violence. So I am going to skip over these questions. And I'm going to ask if there are any questions and if Phoebe want to say anything, or people want to write in or I don't know how you sometimes you do it if you if you give people ask the questions verbally, or write them in what do you

46:08
Yeah, it's just tricky with the way that the Zoom webinars are set up for people to ask directly, but um, I would say like you can right into the q&a or into the chat. That either way works. Okay,

46:24
so here's your chance to ask questions. I did go over some of the some of this best, I could have done it in three hours, but I also respect your time. And your time, Phoebe as well. And Gail? So are there questions?

46:44
Yeah, let's give people a minute to write in some question writes.

47:04
Actually, while you're writing in, I could think of a simple thing to do. There was an agency in New York, that New York State I'm gonna say that did HIV testing. And they couldn't figure out why people who were gay were not coming to them for HIV testing. And then they took a pride decal, and they put it in the window. And guess what? Everybody started coming. So there's sometimes there are simple things that you can do that you have control over, you don't always have control over a lot of things. But sometimes within your own agency or department, you look at what can I do to make things safer for people?

47:58
Okay, it looks like you gave a comprehensive talk. Did you want to go back to? I know that you skipped the questions at the end? Oh, okay, what is the best way to work with HIV positive patients who may have trauma history and are non-adherent with medications? And treatment?

48:18
goes? That's a good question. And that's a complex question. Best way to work with HIV positive patients. Um, I always say, start off with, you know, those counseling 101 qualities about respect. Listening to people, empathy. And, and other people can write in the response to this, by the way, because one of the things is we know, sorry, I'm thinking in my brain of what, what people

deal with. So sometimes people deal with what's, what do you have at hand that you deal with first? So in this case, it looks like you're talking about non adherence to medication. So I would tend to focus on that and see where people are in terms of stages of change. And also, what can you do to help them be adherent to them, if they're not going to take them that that's a whole nother thing. Or if they're going to take them in a way that can be dangerous. That's another thing to address. Sometimes the trauma history comes up later, like you don't know it, but you're seeing their reactions by people to it. And so that is something to kind of look at to sometimes they may feel comfortable telling you about the trauma and if they do and you can make a referral. That I think that's a really good thing, but it's Not like you hand somebody that referral, you believe what they say. And then you find out somebody at your site, I don't know where most of you are from the state of New York and actually, I've trained in Buffalo, Syracuse, Rochester, Binghamton, Albany, New York, all that there's many people who are specialists in trauma. So that's a, that's probably a good thing. If they're not, it's important to find out somebody with that. I'm babbling on this one. But I think it's a complex thing, you know, when you look at kind of depends, and actually, what's their plan? Like, why are they there? Are they there to take? Why are they there? Are they there to take to get medication? Or are they not? You know, sometimes you can just find out kind of like one thing that really flicks people, what's going to be the hook in this case?

51:12
Oh, yeah, thing, I think that's a good thing is if you're talking or talking about the medication is, you know, what prevents you from taking the medication. And it could be a variety of things. You know, they don't like the pills. They don't feel comfortable taking them at home. They make them sick. So I think I might start with that, but, and ask them and I sometimes rather than say why I say, you know, I'll say like, what prevents you from taking the medication? And then I always say, pretend you have like tape on your mouth, by the way, keep your mouth shut and see what see what they say. Sometimes people used to have groups like treatment adherence groups, and that was helpful because sometimes a peer could tell another person

52:06
I'm sorry to interject. Mary, I'm having difficulty hearing you. I think your internet connection might be going in and out. Thank you so much, and have a great

52:18
day
[End Transcript]