



Abuse and Trauma: Lessons for HIV Prevention and Care

AN HIVISION PUBLIC FORUM



“Tonight we bring together expertise, scientific evidence, and the community to explore the health implications of abuse and trauma, which are among the broadest avenues of HIV risk.

We want you to hear the research and the practice, and apply it to your own work. We want to face the stigma that still surrounds sexual abuse and mental health, and to help people devise healthy strategies for dealing with trauma.”

—Mark Cloutier

On October 22, 2008, in partnership with the Trauma Recovery and Rape Treatment Center, Community United Against Violence (CUAV), and Women Organized to Respond to Life-threatening Disease (WORLD), the San Francisco AIDS Foundation (SFAF) held its fifth event in the HIVision forum series. “Abuse and Trauma: Lessons for HIV Prevention and Care” convened researchers, providers, and community members to discuss the challenges that abuse and trauma pose to physical and emotional health and well-being in the context of HIV prevention and care.

Invited panelists were **Ann Brennan**, RN, MSN, ANP/PNP, Nurse Practitioner and Medical Advisor for San Francisco General Hospital’s Trauma Recovery and Rape Treatment Center; **John Williams**, MD, Assistant Professor of Psychiatry and Behavioral Sciences and Associate Director of the Sexual Health Program at the University of California, Los Angeles; **Cheryl Gore-Felton**, PhD, Associate Professor of Psychiatry and Behavioral Sciences at Stanford University Medical Center and Director of Clinical Intervention Research with the Center on Stress and Health at Stanford University School of Medicine; and **Tim Ryan**, RN, MSN, Manager of Clinical Health Services for Magnet, a gay men’s community health center and a program of SFAF, located in San Francisco’s Castro District. The forum was moderated by **Michael Siever**, PhD, founder of the Stonewall Project and Director of Behavioral Health Services for SFAF.

The purpose of this forum was to examine the links between trauma, HIV risk behaviors such as substance use and unprotected sex, and HIV disease progression—and how these links can be broken. In his opening remarks, **Mark Cloutier**, SFAF’s Chief Executive Officer,

noted that trauma and abuse cross-cut many areas where SFAF actively works to promote health. For example, half of the HIV-positive people surveyed in one study had experienced a traumatic event in the course of their lifetime, and among HIV-positive gay men, those diagnosed with depression—a common side effect of trauma—progressed to AIDS on average 1.4 years sooner than those who were not depressed. As Cloutier observed, “These lines we can draw from childhood sexual abuse to greater risk behavior, from depression to disease progression, from violent assault to treatment adherence, are pronounced and very disturbing.”

Following is a summary of the panel and audience discussion and what emerged as lessons for HIV prevention and care in the context of abuse and trauma.

How do we define trauma, and how subjective are these definitions?

“One hundred percent subjective. It has to be... The trauma and abuse that these individuals experience is [understood] only through their stories and their telling of what happened during the event.”

—Ann Brennan

The panelists agreed that defining trauma is a challenge, because the term is extremely subjective; what is traumatic to one person may not be experienced as traumatic by another. As Ann Brennan explained, the meaning an individual assigns to a traumatic experience can only be understood within the context of that person’s life; for example, a rape or assault may not be the worst thing that has ever happened to a given patient.

Cheryl Gore-Felton and John Williams added that sociocultural norms influence that subjective experience—“how we define what’s okay and what’s not okay,” as Gore-Felton put it. Williams noted that, for African-American men in particular, “to come in and say that they were a victim of child sexual abuse has larger implications for their identity,” and these implications may make such men reluctant to acknowledge traumatic events or label them as abuse.

Brennan and Tim Ryan explained that defining what constitutes intimate partner violence (IPV), an underreported form of trauma, is especially difficult in the age of

Internet dating, when the “intimate partners” involved may have had an online-only relationship prior to the assault. The panelists concurred that the subjective nature of traumatic experiences necessitates that medical and mental health care practitioners keep their own opinions in check until they have established trust and rapport with the trauma survivor. For both patient and provider, Ryan said, treating trauma is “very much a journey.”

What kinds of trauma do you most frequently encounter, and how do the individuals “present,” or describe their experiences?

“It runs the gamut. In the research trials that I do, people come in with histories of childhood sexual abuse, interpersonal violence like rape, beatings, robbery, burglaries...as well as physical abuse as a child.... [But] people don’t always say, ‘Look, I was abused.’”

—Cheryl Gore-Felton

Gore-Felton commented that, although her research participants present with a variety of traumatic experiences, her research also focuses on trauma survivors’ reactions to everyday stressors—missing the bus, being overdrawn at the bank—which may be experienced as re-traumatization. Williams described these everyday experiences as “microinsults” which may not be related to the original traumatic event but may trigger the same feelings surrounding that event, no matter how long ago it occurred. “Those past experiences can be as raw as something that happened to them ten minutes ago,” Williams agreed.

Williams, Gore-Felton, and Ryan explained that, in their experience, trauma survivors may present with clear signs of abuse—bruises or scars, for example—but, as Ryan said, “not everybody can get to that point where they can say ‘I’ve been abused’ or ‘I’ve been beaten by my partner.’” Brennan described a somewhat different experience; with her clients at the Trauma Recovery and Rape Treatment Center, she said, “I know that they’re there because they’ve been sexually assaulted. My next question is, ‘What can I do for you?’”

Unique to Ryan’s experience is minimizing the potential psychological trauma surrounding an HIV-positive diagnosis. “There’s a tremendous amount of anxiety, no matter how many times you’ve been tested for HIV,” Ryan observed. When a test comes back positive, clinic staff rearrange their schedules so that the provider who performed the test has ample time to give the diagnosis and provide support, counseling, and referrals to the client.

Psychological trauma can be as devastating as physical abuse but offers its own distinct challenges; as Gore-Felton observed, “People can tell you if they had a broken bone or if they have a scar that’s visible, but it’s the inside scars that I find the hardest to treat and the hardest to detect.”

A growing body of research indicates that a history of trauma is associated with both increased risk of HIV transmission and disease progression. What best explains these links?

“When we start looking at adults who have [trauma] histories,...we find that what we have in an adult body is really a

child who doesn’t have...the ability to negotiate what happens to them as an adult, because as a child, it was taken away.”

—John Williams

A traumatic event, such as sexual abuse, can interfere with normal psychological development and inhibit the establishment of self-protective boundaries, Williams explained. Similarly, experiences such as chronic sexual abuse may contribute to what Ryan referred to as “learned helplessness.” Both panelists pointed out that lack of boundaries and learned helplessness can compromise traumatized individuals’ ability to negotiate safer sex and protect themselves or their partners from HIV.

In addition, survivors of trauma may mirror their childhood experiences in their adult relationships. For example, Williams noted that survivors of sexual abuse who were “just used for sexual gratification” during childhood may become hypersexual in adulthood and have a high number of sex partners—a known risk factor for HIV infection.

Chronically abused individuals, Gore-Felton added, may learn unhealthy ways of coping with their traumatic experiences. These coping strategies may include addictive behaviors, such as heavy drug and alcohol use, which offer temporary escape from the memories and feelings surrounding the trauma—at the cost of increased vulnerability to HIV infection through needle sharing or unprotected sex while intoxicated. As one audience member mentioned, another coping strategy is dissociation, in which the traumatized individual involuntarily “freezes up” and feels as if he or she is not really present. If dissociation occurs during sex—perhaps in response to memories of past sexual abuse—the individual may be unable to negotiate safer sex practices.

Gore-Felton described ways in which the body’s response to stress can affect HIV disease progression. Stressful situations, she explained, activate the hypothalamic-pituitary-adrenal axis, a system of glands in the brain and body that helps regulate mood, emotions, and the immune system. This activation in turn creates a “hyper-aroused” state by elevating heart rate and blood pressure, and by stimulating the release of hormones—including cortisol, a hormone that weakens immune response. For HIV-positive individuals, this physiological response to stress manifests in lower CD4 cell counts and other biomarkers of disease progression and poor general health. As Williams put it, “The body reacts to stress in a global way.”

In addition, behavioral responses to the hyperarousal triggered by trauma and stress can complicate HIV treatment and prevention. As Gore-Felton observed, many people turn to drugs and alcohol to quell hyperarousal, which may in turn raise their risk of acquiring or transmitting HIV and/or damaging their health. Missed medical visits or poor adherence to anti-HIV medications may also stem from this behavioral response to stress, contributing further to disease progression.

How do issues of gender, sexuality, and race complicate the interaction between trauma and HIV?

“There are several [male sexual assault survivors] that I’ve seen, that one of the first things they say to me once they come in, or to one of my providers, is, ‘I’m not gay.’”

—Ann Brennan

Each panelist brought a different perspective on how gender and sexuality factor into HIV risk among trauma survivors. Brennan described how, for many of the men she sees in the emergency department, the perceived implications of sexual assault are more devastating than the assault itself; in these cases, damage to mental health and emotional well-being—and a concomitant increase in HIV risk—can be mitigated by immediate access to counseling. Gore-Felton commented that such reactions speak volumes about a culture of homophobia, in which fear of stigmatization can be the predominant response to a physically and emotionally painful experience.

Homophobia can also contribute to an invalidating environment for young people who come out as gay, lesbian, bisexual, or transgender; Ryan recounted that, for many Magnet clients seeking HIV testing, “the only community they know is the community in the Castro, because they told their family back in Ohio or Illinois or Indiana...and their family said, ‘You’re dead to us.’”

Research suggests a link between child sexual abuse and sexual identity, and, as moderator Michael Siever pointed out, “Men who have been sexually abused as children start to wonder, ‘Am I gay because of that?’” Williams cited studies demonstrating that men with a history of trauma are seven times more likely to be gay or bisexual in adulthood than are men who have not experienced abuse; however, the interpretation of these data should take into account the research questions themselves. For example, Williams noted, studies that asked men about the age at which they came out found that boys who came out at a younger age had a greater rate of sexual abuse than those who came out later, suggesting that boys who are openly gay may be more likely to be targeted for abuse.

Gore-Felton observed that, while research on adult men’s reactions to childhood trauma is limited, there is evidence that women and men respond differently to traumatic experiences. For example, while women tend to exhibit depressive symptoms, men are more likely to respond with anxiety, post-traumatic stress disorder, anger, and even hostility, which can complicate treatment. “For minority men who are depressed and have an anxiety disorder,” Gore-Felton explained, “the depression often goes undiagnosed, because all the provider sees is the anger and the anxiety.”

Gore-Felton raised another important point about barriers to treatment and prevention for these clients: “Who are the providers who are treating black men?” she asked. “What’s their ethnic background?” Lack of access to providers of the same race or ethnicity may hinder pa-

tient-provider trust and rapport and undermine health and prevention messages. “It speaks to recruiting more qualified ethnic folks into the field of providers,” Gore-Felton said, “so that people can go into a place and [think], ‘this feels like home.’”

Referring to his work on HIV prevention interventions for African-American men who have sex with men and are trauma survivors, Williams acknowledged a number of misconceptions, stereotypes, and expectations that can play out in intimate relationships and increase HIV risk. “Black men are supposed to be ‘well-endowed,’” Williams said, and this stereotype can factor into reluctance to use condoms: “You know, ‘We can’t find condoms that fit,’ and it goes on and on and it places them at risk.”

In addition, a history of “micro-aggressions”—subtle experiences of racism and discrimination, such as being discreetly followed by a store security officer—can compound a history of trauma and other stressors and have a tremendous impact on risk behavior, as well as on immune function, HIV disease progression, and overall health. As Gore-Felton explained, there is an established association between cumulative stress (including everyday stressors, micro-aggressions, and traumatic events) and not only high-risk behavior and sexually transmitted infections (STIs) but also diabetes, cardiovascular disease, and kidney disease.

Given the context of abuse and trauma, what are the lessons learned, and where do we need to go in of the area of HIV prevention?

“I taught a class at Magnet for our Magnet providers, and [I asked], ‘How many of you, when you were in college or when you first began your practice, were taught how to talk to someone about sex? [About] who are they having sex with, and how many sex partners they have?’ And unfortunately, not one hand rose in my class.”

—Tim Ryan

One lesson clearly emerged from the panel discussion: For messages about HIV disease progression and HIV prevention to be effective, providers must be able to talk openly with patients about their sexual activities and other behaviors that influence their health and risk.

As Williams noted, “If you send in a medical student to do a sexual history of a patient, they will do it textbook-perfect. However, if you do not mention that the patient they are seeing has a problem that is sexually related, they will avoid taking a sexual history like the plague.” Gore-Felton agreed: “The thing we have to get comfortable with as providers is, we have to be able to talk about *sexuality*,” including what constitutes healthy sex and what sex means to clients’ self-esteem.

According to Ryan, discomfort with discussing sexuality drives many clients—including some with health insurance—to seek STI testing and treatment at Magnet. Ryan noted that, when he asks these clients about their relationships with their regular physicians, he hears,

“That’s why I come to Magnet; I can’t talk to my doctor about this,’ or ‘I have shared information with my physician about my sexual orientation and who I have sex with, and immediately got shut down.’”

Brennan stressed, however, that patients need to be willing to tell their providers, “You’re not asking me the right questions,” and to advocate for their own health: “Demand from the health care providers that you see the kind of service that you deserve.”

What resources are available to people who have experienced trauma and are living with or at risk for HIV?

“We’re giving people things that they can take with them, that they can use right then and there. That’s been critical to people living with HIV... They want real-world, real-life tools that they can use, not theories.”

—Cheryl Gore-Felton

The panelists suggested a number of resources for managing trauma, HIV risk, and HIV health, including counseling, interventions and programs, and mind-body techniques.

Ryan described one intervention that empowers through teaching “sexual orientation pride”—even for clients who have not made their sexuality public—and another that helps individuals conceptualize their lives as linear processes, acknowledging past experiences but also orienting participants toward the future. Gore-Felton described a program for HIV-positive trauma survivors, called RISE (Realizing I am Somebody Exceptional), that creates the supportive, validating environment that so many abused individuals lack and provides a safe space to heal from trauma.

In one of her HIV prevention studies with HIV-positive participants, Gore-Felton recounted, the most severely traumatized individuals were still engaging in risk behaviors. For these participants, she developed an intervention to target hyperarousal and other trauma symptoms with practical, accessible tools like diaphragmatic breathing and cardiovascular exercise. Ryan noted that, while meditation and deep breathing exercises can be helpful at any time, “they become more important when your life is more chaotic.”

Gore-Felton also described the techniques she uses with clients who tend to dissociate during stressful events. For these individuals, learning to deliberately relax their muscles or think about where in their bodies their tension localizes can help prevent dissociation. “We teach people how to feel their bodies, as strange as that sounds,” she said.

Brennan and Gore-Felton offered some practical advice to practitioners, as well. Gore-Felton observed that if providers find themselves doing unusual things for a patient, such as giving out a home phone number or offering money for the bus, then they may be dealing with a client who has an undisclosed trauma history. “People will recreate their trauma experience in an effort to gain

mastery over it,” Gore-Felton explained. For example, a patient who was abused by his or her father may try to approximate a child-parent relationship with a male provider.

To help detect past or current abuse or trauma, Gore-Felton employs a brief trauma screening questionnaire adapted to the HIV and primary care setting. Brennan added, “you don’t ask these questions one time. You ask them every single time, because it could be the tenth time that [the client] is able to divulge to you, the health care provider, that something is going on.” Brennan also emphasized the importance of partnerships between medical and mental health care providers, so that patients who do disclose abuse or trauma can be referred for counseling and substance use programs, as needed.

Conclusion

Abuse and trauma can create lifelong challenges to physical and emotional health. Among people living with HIV, child sexual abuse, violence, rape, and psychological abuse are more common than in the broader population. The links between trauma and HIV are complex but clear; many conditions and behaviors commonly associated with trauma—including anxiety and depression, drug and alcohol use, unprotected sex, and having a high number of sexual partners—are also known risk factors for HIV infection and disease progression.

Participants in this HIVision forum examined these links, and how trauma survivors and their medical and mental health care providers can break them. Effective HIV prevention and care require that providers and patients learn to communicate more openly about the experiences and behaviors that put patients at risk for acquiring or transmitting HIV and contribute to faster disease progression in HIV-positive individuals. And as Cloutier said in his opening remarks, “trauma does not have to lead down a risk-taking path,” nor toward declining health and AIDS. With the help of counseling, mind-body techniques and exercise, and targeted interventions, survivors of abuse and trauma can learn to manage their responses to traumatic events and everyday stressors and mitigate their HIV risk or live more healthily with HIV.