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# *Providing Sensitive Care for Adult HIV-Infected Women With a History of Childhood Sexual Abuse*

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*Childhood sexual abuse (CSA) is a serious public health issue. Women with HIV who have a history of CSA are at increased risk for sporadic medical treatment, nonadherence to HIV medications, and HIV risk behaviors. These associations pose a challenge to providing health care for this population and are complicated by the possible psychological sequelae of CSA, such as anxiety, depression, dissociation, and posttraumatic stress disorder. This article reviews the effects of CSA on the health status of women with HIV, barriers to treatment adherence, suggested components of trauma-sensitive medical care, and mental health approaches. A trauma-informed, trauma-sensitive care model that addresses barriers associated with health care for women with a history of CSA is suggested. Specific recommendations are offered for the provision of effective clinical care for women with HIV who also have a history of CSA to help HIV care providers better recognize and appreciate the distinct needs of this patient population.*

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Childhood sexual abuse (CSA) is a serious public health problem. Estimated rates of CSA in women in the United States have ranged from 20% to 25% (Dube et al., 2005; Felitti et al., 1998). One in five women is raped in her lifetime, and of these, approxi-

mately half experience rape before the age of 18 years (Centers for Disease Control and Prevention [CDC], 2012). More than one third of women who were raped as minors are also raped as adults. Women with HIV have particularly high rates of abuse and trauma, with reported rates as high as 2-fold that of the general population (Briere & Elliott, 2003; Fergusson, Boden, & Horwood, 2008). CSA in women has potential lifelong psychological effects that are associated with a high risk of HIV acquisition and poor adherence to medical care following a diagnosis of HIV (Maniglio, 2009).

A continuum of risk exists for women who experience CSA, with early abuse leading to later abuse and violence, which in turn may increase the risk of behaviors that lead to HIV infection (Fergusson et al., 2008). The associations between CSA and later engagement in sexual risk behaviors have been well documented, with CSA linked to sex work, sexual risk behavior, multiple sex partners, and substance abuse (Greenberg, 2001; Wingood & DiClemente, 1997; Wyatt et al., 2002; Zierler et al., 1991). Women who have experienced

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CSA have a 2-fold elevation in risk for lifetime domestic violence and a 4.25-fold increased risk of illicit drug use compared with women without such a history (Fergusson et al., 2008). CSA survivors have reported a lifetime history of greater exposure to various traumas as well as greater levels of mental health symptoms (Banyard, Williams, & Siegel, 2001a).

The intention of this review article is to help sensitize HIV providers to the distinct needs with which women with a history of CSA may present. It is recommended that HIV care programs for women address the effects of CSA. Delivery of health care that acknowledges and addresses the psychosocial sequelae of sexual abuse and violence may help increase treatment and medication adherence rates for women with HIV. This article reviews the effects of CSA on the health status of women with HIV, barriers to treatment adherence, suggested components of trauma-sensitive medical care, and mental health approaches that may enhance HIV care and promote adherence.

### Defining CSA

The search terms that were utilized for this review included *childhood sexual abuse*, *child sexual abuse*, and *childhood sexual trauma*. The National Society for the Prevention of Cruelty to Children (n.d.) defined CSA as “persuading or forcing a child to take part in sexual activities, or encouraging a child to behave in sexually inappropriate ways” (para. 1). The legal definitions of CSA by state may encompass different types of sexual activity, including voyeurism; sexual dialogue; fondling; touching of the genitals; vaginal, anal, or oral rape; and forcing a child to participate in pornography or prostitution (Childhood Welfare Information Gateway, n.d.).

Prevalence rates of CSA vary among studies according to the definitions used. Because of the varying social, legal, and moral definitions of CSA, there is little consensus as to the cutoff age or types of sexual activities that are considered abuse for the purposes of research. Most studies use a cutoff point of 16 to 18 years, but because the majority of occurrences of abuse take place during the prepubertal years of 8 to 12 years, the later cutoff points do not affect the prevalence data (Coleman & Coleman, 2002). In one meta-analysis of CSA, the majority of studies (70%) defined

CSA as occurring if a sizable age discrepancy exists between the child or adolescent and the other person regardless of the younger person’s willingness to participate (Rind, Tromovitch, & Bauserman, 1998). Twenty percent of the studies in that meta-analysis limited the definition of CSA to only unwanted sexual experiences. Three fourths defined CSA as including both contact and noncontact (e.g., exhibitionism) sexual experiences, whereas one fourth restricted the definition to contact experiences only (Rind et al., 1998).

### Effects of CSA on Health Status

CSA is more prevalent among women living with HIV than women in the general population and, thus, it is important to examine the relationship between CSA and HIV as it relates to women’s health care and health outcomes (Koenig, Doll, O’Leary, & Pequegnat, 2004). CSA is associated with a number of physical, psychological, and behavioral consequences for the survivor (Maniglio, 2009). Symptoms resulting from CSA likely persist long after the abuse has ended, and, therefore, it is important to consider the long-term nature of these effects in defining the impact of CSA on women’s overall health status.

### CSA and HIV

There appears to be a relationship between CSA and HIV risk behavior (Arriola, Loudon, Doldren, & Fortenberry, 2005), with HIV infection in adulthood being a possible health-related consequence for survivors of CSA (Zierler et al., 1991). There is an association between CSA and subsequent sexual risk behaviors in women, with a reported 7-fold increase in HIV risk behaviors associated with early and chronic sexual abuse (Bensley, Van Eenwyk, & Simmons, 2000; Senn, Carey, & Vanable, 2008). Specifically, CSA has been related to later engagement in unprotected sexual intercourse, sex with multiple partners, and sex trading (i.e., sex for money, drugs, shelter; Arriola et al., 2005). However, it is important to note that it remains unknown how many women are infected with HIV by a sexual abuser during childhood. CSA survivors are at high risk for revictimization. One study found that 67%

of CSA survivors had experienced other unwanted sexual activities after the initial abuse (Coid et al., 2001).

Despite the mounting evidence that has suggested negative health outcomes associated with CSA, it remains unclear what moderates or mediates the relationships between CSA and these health consequences. Although the ACE (Adverse Childhood Experiences) study assessed childhood maltreatment, neglect, and family dysfunction in addition to CSA, many studies have not accounted for these potentially influential variables (e.g., socioeconomic status, family environment, genetic vulnerabilities) and, therefore, the ability to draw causal inferences has been compromised (Maniglio, 2009; Senn et al., 2008). A meta-analysis of studies by Rind et al., (1998) found that a negative family environment was also associated with CSA and, therefore, was a possible confounder. Because women who have experienced CSA have increased rates of HIV infection, it is important to recognize the direct and indirect influences of CSA on women's overall health, especially for women with HIV infection.

### Physical Health Effects

Women who were sexually abused at a young age are at risk for a host of physical health problems and disorders (Leserman, 2005). Previous reviews and meta-analyses have reported associations with gastrointestinal, urinary, gynecologic, and cardiopulmonary symptoms; obesity; pelvic pain; cancers; heart disease; headaches; generalized pain; and medically unexplained conditions (Havig, 2008; Irish, Kobayashi, & Delahanty, 2010; Leserman, 2005; Talbot et al., 2009). However, it is notable that not all types of CSA necessarily produce similar or predictable outcomes. Certain characteristics, such as the frequency of the abuse or the extent to which the abuse involved penetration, have been associated with a greater severity of these physical symptoms and conditions (Leserman, 2005). CSA that persists over time has been related to more psychological symptoms than sexual abuse incidents that occur less frequently (Molnar, Buka, & Kessler 2001). Penetration is considered the most invasive type of CSA and has been associated with poor physical

and psychological outcomes across a number of initial studies, including in women from medical clinics (Springs & Friedrich, 1992) and community samples (Mullen, Martin, Anderson, Romans, & Herbison, 1993).

However, the invasiveness of the abuse is not necessarily indicative of psychological adjustment following abuse (Young, Riggs, & Robinson, 2011). Multiple abusers or abuse that is perpetrated by a family member can have significant deleterious effects, but these effects can depend on a number of factors (Maikovich-Fong & Jaffee, 2010; Springs & Friedrich, 1992). In one study, 68% ( $n = 207$ ) of the sample were girls who experienced sexual abuse perpetrated by a family member, but the experience was not significantly associated with behavioral or emotional problems. These results suggested that familial sexual abuse may only partially influence physical and psychological outcomes (Maikovich-Fong & Jaffee, 2010). Although many studies have posited that CSA that occurs as a result of incest is more damaging because of the close relationship between victim and perpetrator, it is important to consider the potential confounding effect of the fact that family members have more access to the child than do strangers; therefore, the abuse may be more severe or of a longer duration by virtue of accessibility (Yancey & Hansen, 2010).

### Psychological Effects

The relationship between CSA and psychological morbidity is difficult to deconstruct due to the number of potential confounding factors, such as genetic predisposition, family dysfunction, social support, and degree of self-blame for the abuse. In a majority of studies, CSA has emerged as a risk factor for poorer psychological functioning in adulthood, but effect sizes have varied across studies. Therefore, the relationship between CSA and mental health remains unclear (Hillberg, Hamilton-Giachritsis, & Dixon, 2011). Despite these inconsistencies, results from the National Comorbidity Survey have indicated that the prevalence of psychiatric disorders was much higher among individuals who reported CSA than among individuals in the general population (Molnar et al., 2001). Specifically, 78% of women who experienced

CSA met criteria for mood disorder, anxiety disorder, or substance use disorder compared to 48.5% of women in the general population who met criteria for any lifetime disorder (Molnar et al., 2001). Fergusson et al. (2008) found that CSA was significantly associated with mental health problems in adulthood (as measured by the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition [DSM-IV] criteria) and estimated that CSA experience accounted for 13% of the psychological problems in the cohort they studied.

CSA has been significantly associated with depression, anxiety, substance abuse, and posttraumatic stress disorder (PTSD; Maniglio, 2009; 2010; Putnam, 2003). According to the DSM-IV–Text Revision (TR), for a PTSD diagnosis, a person has to have been exposed to an event that must meet two criteria: (a) involve actual or threatened death or injury or damage to self or others, and (b) the person’s response involves intense fear, helplessness, or horror (American Psychiatric Association [APA], 2000). Childhood sexual abuse is included in the DSM-IV-TR’s subsequent list of potentially traumatic events. Proposed revisions for the DSM-5 aim to expand this definition of trauma to include “actual or threatened sexual violation” (APA, 2010). *Actual sexual violation* refers to direct sexual abuse, whereas *threatened sexual violation* refers to the possibility of sexual abuse occurring in the near future or personally witnessing abuse inflicted upon others (APA, 2010). The revised diagnostic criteria also include the following symptoms and behaviors associated with PTSD: intrusion symptoms, including distressing memories or dreams, dissociative reactions (e.g., flashbacks), and psychological distress at triggers or reminders of the trauma; avoidance of stimuli (i.e., internal and external reminders) associated with the trauma; negative cognitive or mood alterations (e.g., persistent negative expectations, feelings of detachment from others, pervasive negative emotional state, and alterations in arousal and reactivity such as irritability, reckless behavior, and hypervigilance; APA, 2010).

The diagnostic criteria for PTSD include re-experiencing the traumatic event, avoiding stimuli that resemble the event, and numbing of emotional responsiveness and increased arousal (Breslau,

2009). PTSD and subthreshold PTSD symptoms have emerged as serious consequences of CSA (Glover et al., 2010; Paolucci, Genuis, & Violato, 2001). The risk of experiencing PTSD is 10 times higher for individuals who were sexually abused after age 12 years, whereas the risk of experiencing depression is higher for individuals who were sexually abused prior to age 12 years (Schoedl et al., 2010). Women with *severe CSA* (defined as digital penetration, attempted rape, rape, oral copulation, or anal sex) were more likely to report greater levels of depression compared to women who experienced *moderately severe CSA* (defined as fondling and frotage; Sciolla et al., 2011).

CSA is significantly associated with dissociation, which is a mental process that causes a lack of connection in a person’s thoughts, memory, and sense of identity (Nelson, Baldwin, & Taylor, 2012). Dissociation may manifest itself in many ways; patients may seem to “space out” during clinical examinations, ignore early symptoms of illness, or be resistant to changes in behavior. Often these patients are considered difficult and frustrating by their health care providers, especially if the history of CSA is not known.

Adult survivors of CSA are more likely to find clinical examinations—specifically gynecological examinations—to be negative, traumatic, uncomfortable, or painful (Robohm & Bittenheim, 1997). Examinations may trigger flashbacks, bring on overwhelming feelings of helplessness, or cause feelings of detachment in CSA survivors.

It is likely that additional sociodemographic or psychosocial variables are implicated in the relationship between CSA and psychological outcomes, as discussed earlier. For example, when considering the role of family dysfunction in psychological outcomes for individuals with a history of CSA, the relationship between CSA and later psychological distress was weakened (Bhandari, Winter, Messer, & Metcalfe, 2011). In addition, for women, disclosure of CSA and degree of self-blame were also related to later psychological functioning (Glover et al., 2010). These findings suggest that a number of variables that influence mental health and psychological adjustment may moderate or mediate the relationship between CSA and psychological distress.

## Adherence to Medical Care and Antiretroviral Therapy

A clear association has been documented between the negative effects of CSA and HIV treatment adherence, including sporadic medical treatment and non-adherence to HIV medications (Briere & Elliott, 2003; Mugavero et al., 2006). PTSD has been associated with lower medication adherence for women with HIV, along with a higher likelihood of detectable viral loads (Boarts, Sledjeski, Bogart, & Delahanty, 2006; Safren, Gershuny, & Hendriksen, 2003). Women with a history of CSA and other traumas have also been found to be less likely to have social support systems; a lack of social support systems has been found to be a predictor of lower outpatient medical appointment attendance among persons infected with HIV (Catz, McClure, Jones, & Brantley, 1999). Self-esteem and self-efficacy have also been shown to be mediators of treatment adherence in women with HIV (Liu et al., 2006).

PTSD and depression serve as important factors that influence a woman's interactions with the health care system and her ability to adhere to treatment recommendations. Women with a history of CSA often experience nonspecific psychological symptoms that can impact their health. Women who have endured traumatic experiences may have suffered many losses and may have difficulty managing their emotions and envisioning a future. As such, "they are frequently in danger, lose emotional control, or are so numb that they cannot access their emotions, have many signs of unresolved loss, and are stuck in time, haunted by the past, and unable to move into a better future" (Bloom, 2007, p. 14). All of these symptoms may prevent them from fully participating in self-care, thus threatening their overall mental health and well-being.

The most common manifestations of PTSD are re-experiencing the trauma, avoidance, and dissociation. Carlson et al., (2001) found that dissociative symptoms are more strongly associated with sexual abuse than with physical abuse. Dissociation has also been associated with both trauma exposure and mental health symptoms (Banyard, Williams, & Siegel, 2001b). Survivors of trauma may have learned to dissociate from the pain and suffering that have accu-

mulated as a result of the trauma. They may have learned to disconnect from the body and to move into an altered state in order to get emotional distance. Many times, this behavior occurs without the person's awareness. When the trauma is connected to the HIV diagnosis, the person may not understand the consequences of not engaging in medical care. She may understand intellectually, but not emotionally, the connection between taking antiretroviral therapy and survival. This barrier may be what prevents a woman from engaging in and following through with care. Women may be incapable of achieving what the medical model recommends in order to survive. Each time a person who has had a traumatic experience confronts new trauma, such as a diagnosis of HIV, there may be a reenactment of the past (Kimerling, Armistead, & Forehand 1999). Additionally, throughout pregnancy and delivery, women with a history of CSA may be confronted with memories of past sexual abuse, which can reduce engagement in prenatal care and can complicate outcomes (Leeners, Richter-Appelt, Imthurn, & Rath, 2006).

CSA survivors have reported difficulty swallowing medications, a condition that may be diagnosed as *globus pharynges* or *globus hystericus*, or the feeling that there is a lump in the throat that causes difficulty in swallowing. This condition is considered to be a *conversion disorder*, in which psychological conflict results in neurological symptoms that cannot be explained by organic conditions (Finkenbine & Miele, 2004). The problem can be extremely detrimental to one's health because poor adherence to HIV medications may result in a higher viral load, resistance to medications, and faster disease progression. This situation is especially problematic during pregnancy, when the administration of antiretroviral medication is crucial to preventing the risk of perinatal transmission (Panel on Treatment of HIV-Infected Pregnant Women, 2011).

## Components of Trauma-Sensitive Health Care

The introduction of trauma-sensitive practices in the treatment setting can be beneficial to both providers and patients to help offset the effects that CSA has on adherence to care. Recommendations for trauma-sensitive best practices, including screening all

patients for CSA and performing sensitive clinical examinations, are discussed subsequently. Providers have an opportunity to interrupt the cycle of abuse by creating new patterns of health and well-being for patients. Guidelines to use as universal precautions for the provision of trauma-sensitive care during medical examinations for all women are presented in Table 1 (Coles & Jones, 2009).

## Screening

Trauma-sensitive care includes the integration of history-taking that pertains to childhood sexual experiences. Despite evidence that demonstrates patient acceptance of routine CSA screening and evidence of physicians' beliefs that they can help patients with problems stemming from sexual abuse, inquiries about sexual abuse history were not made at 89% of initial visits or at 85% of annual visits (Friedman, Samet, Roberts, Hudlin, & Hans, 1992).

Screening can occur either by self-administered questionnaire or through interviews conducted by health care providers. The following question was used to assess history of CSA by the ACE study, a large study that assessed the impact of adverse childhood experiences on health behaviors and outcomes: "During the first 18 years of life, did an adult, relative, family friend, or stranger ever (a) touch or fondle your body in a sexual way, (b) have you touch their body in a sexual way, (c) attempt to

have any type of sexual intercourse with you (oral, anal, or vaginal), or (4) actually have any type of sexual intercourse with you (i.e., oral, anal, vaginal)?" (Dube et al., 2005, p. 432). It has been recommended that screenings incorporate questions about specific actions that can allow patients to accurately disclose their history even if they do not identify themselves as abuse survivors, such as, "Has anyone ever touched you sexually against your will?" Several tools are available for clinicians to screen for a history of CSA. The Centers for Disease Control and Prevention published a compendium entitled *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Health Care Settings*. Included is a screening tool specific to CSA, called the Sexual and Physical Abuse History Questionnaire, as well as several instruments available in English and Spanish that can be used to screen patients for current sexual or physical abuse (Basile, Hertz, & Back, 2007).

## Clinical Care and Examinations

CSA survivors and other victims of violence have been injured by abuse of power, and misuses of power in health care systems can further wound these individuals. Taking an egalitarian approach to caring for patients is a key way to avoid a hierarchical patient-provider power dynamic that may retraumatize survivors of CSA. Acknowledging that the

**Table 1. Suggested Guidelines for Medical Examinations of HIV-Infected Women**

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Always ask for consent, even if the patient is familiar with you and has been examined by you in the past. Ensure continued consent <i>at each step</i> throughout the examination.
Explain what will be done during the examination or procedure, how it will be done, and why it is necessary.
Ask whether the woman would like an escort in the room during the examination.
Do not assume that any procedure or examination is routine. For a CSA survivor, any examination or procedure could produce fear and anxiety.
Throughout the examinations, observe a woman's body language. Ask "Are you comfortable with this?" or "Is it OK if I continue with the exam?" Stop or slow down at the woman's request or in response to her distress.
Avoid phrases such as "This won't hurt" or "Just relax," which could be triggers for some women, reminding them of what their childhood abuser may have said. Be frank about any pain, pressure, or discomfort they may expect to encounter during the examination or procedure. Give specific advice on how to relax if needed.
If you are also going to examine the woman's child(ren), use similar precautions. Ask for permission to examine her child(ren) and carefully explain what you are going to do.

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Note: CSA = childhood sexual abuse.  
Data from Coles & Jones (2009).

patient has ultimate decision-making power and developing care options that are based on the patient's expressed needs and desires can engage the patient in her own care (Seng & Hassinger, 1998). Consulting survivors about their experiences with the health care system and inquiring how health care providers can be more sensitive to their needs may help form partnerships in treatment and care.

When adult women survivors of CSA with HIV infection were asked to define components of sensitive care, the following themes were identified (Schachter, Radomsky, Stalker, & Teram, 2004):

- Patients perceived a lack of control during appointments that decreased feelings of safety and affected treatment adherence;
- Disclosure of abuse to health professionals was most likely to occur when patients felt they would be believed and responded to with calm compassion and overall sensitive care, including respect for personal boundaries and awareness of traumatic effects; and
- Regular verbal check-ins with patients throughout clinical care interactions were appreciated.

Another study of responses from female survivors of CSA compiled the following elements of sensitive care: providers being aware of the potential negative impacts of their language and tone of voice; an understanding that any aspect of the medical interaction—even a smell—could trigger fear or flashbacks in the CSA survivor; providers being aware of patients' body language throughout the interactions; and providers expressing ability and willingness to help patients with a history of CSA (McGregor, Glover, Gautam, & Julich, 2010). Providers' responses to the disclosure of a history of CSA should include assurances of confidentiality, empathetic and empowering responses, and nonjudgmental and nonstigmatized treatment (Havig, 2008).

Women with HIV who have a history of abuse may require more intensive interventions to engage in health care. Such interventions may include the utilization of case managers and social workers who have specific training in abuse, adherence counselors who can follow up with patients closely to assist with

medication adherence, on-site psychological services, outreach and retention specialists, and peer educators. Peer educators share a similar serostatus and/or background with program recipients and are trained to facilitate behavioral changes, provide education and social support, and act as client advocates. Because of the shared experience of living with HIV, peers can enhance the relevance and credibility of health messages (Raja et al., 2008).

### **Educating and Engaging Health Care Staff in Trauma-Informed Care Practices**

The term *trauma-informed services* implies that staff members have been trained to be sensitive to the trauma-related health and psychological issues often present in trauma survivors; *trauma-specific services* refers to treatment of the sequelae of abuse trauma (Jennings, 2004). Both terms refer to a model of care that involves organizational change throughout the entire service system, including staff training, service-delivery processes, and client interactions. The Sanctuary Model, founded by Bloom (2007), is an example of a trauma-informed model for creating and maintaining an organizational culture of safety and nonviolence. Based on trauma theory, the model approaches patient care by assuming that the patient has been injured in some way and needs to rehabilitate in order to heal (Bloom, 1997). It avoids blaming the individual for his or her illness or for the results of his or her injury, such as a lack of adherence to medication or to care visits. Bloom's trauma model relies on a process of recovery and rehabilitation, even if the patient must learn how to cope with a semipermanent or even permanent disability (Bloom et al., 2003). Bloom (1997) also described a pyramid that needs to be interrupted without blaming the patient: (a) childhood adversity such as abuse disrupts attachment and the ability to build healthy relationships with the self and others, which may lead to (b) social-emotional cognitive problems, such as chronic hyperarousal, poor impulse control, and poor judgment, which may lead to (c) high-risk behaviors, which may lead to (d) disease, an increased risk of HIV, disability, and social problems, which may finally result in (e) early death.

### Attention to Mental Health Symptoms

Elevated rates of mental health symptoms in survivors of CSA and the potential impact on medication adherence and clinic attendance, as well as responses to physical examinations, pose challenges in providing health care to this population. Key elements of trauma-sensitive care involve recognizing the psychological consequences of CSA, routinely screening for mental health symptoms, and referring for trauma-specific psychological interventions that may be of value.

A screening tool that was developed especially for primary care settings is the *Primary Care Evaluation of Mental Disorders*, or PRIME-MD (Spitzer et al., 1994). Patients complete a self-report questionnaire composed of 26 items evaluating DSM criteria for the five most prevalent diagnostic categories seen in primary care settings, including depression, anxiety, alcohol, somatoform, and eating disorders. Positive scores are followed with a clinician-administered evaluation. Although the questionnaire has demonstrated relatively strong psychometric properties, the average administration time of PRIME-MD is approximately 8 min. A briefer self-report version, the Patient Health Questionnaire, has also been developed, with overall accuracy, sensitivity, and specificity comparable to the characteristics of the original PRIME-MD, but with the advantage of greater time efficiency (i.e., most providers can evaluate the findings in 3 min or less; Spitzer, Kroenke, & Williams, 1999). Questionnaires that evaluate symptoms specific to distinct diagnoses can also be used. For example, the Center for Epidemiologic Studies Depression (CES-D) scale (Radloff, 1977) or the Hamilton Depression (HAM-D) scale (Hamilton, 1960) can be administered to determine the extent of depressive symptoms. The National Stressful Events Survey PTSD Short Scale (NSESSS) can be used to assess the severity of PTSD symptoms (Bohnert & Breslau, 2011).

The use of screening tools such as these allows the provider to introduce the topic of mental health symptoms, normalize the experience of such symptoms for survivors of CSA, and offer potential options for individualized treatment when necessary. It is crucial to note that, although rates of psychological symptoms may be greater in women with HIV who

also have a history of CSA, not all of these women experience symptoms that warrant treatment. Some may not experience any psychological symptoms, while others may exhibit *posttraumatic growth*, which refers to positive psychological changes that occur following a traumatic event (Lev-Wiesel, Amir, & Besser, 2004). Therefore, psychological referral is not appropriate for all patients.

There are few empirically supported treatments for adult women survivors of abuse and even fewer that specifically address abuse in the context of HIV infection. Treatments that exist are group interventions that target HIV risk-reduction behaviors and adherence to HIV medication (Puffer, Kochman, Hansen, & Sikkema, 2011; Sikkema et al., 2007; Sikkema et al., 2008; Wyatt et al., 2004) and one that targets the reduction of shame and guilt in individuals with PTSD (Ginzburg et al., 2009). Most interventions incorporate psychoeducational components and aim to increase adaptive coping and behavioral skills.

Individual approaches can be tailored to the specific problems and symptoms with which a woman presents. Although treatment from varied theoretical orientations may be beneficial, it is important that mental health providers attempt to fully understand the underlying issues relevant to the presenting problems in the context of a woman's life. This contextual approach entails seeking an understanding of the woman's current phase of life and an appreciation for any cultural, spiritual, religious, political, economic, familial, and medical factors that may be significant for her. In addition, it is crucial to determine how a woman may be affected not only by her diagnosis of HIV infection and her history of CSA but also by her history of other stressful life experiences, past traumas, and current relationships. When making referrals, health care providers can assist by offering mental health providers' information relevant to these factors.

When addressing adherence issues from an individual perspective, one may use motivational interviewing (MI; Miller & Rollnick, 2002). MI is a client-centered, goal-directed style of counseling that helps patients identify and resolve ambivalence regarding behavioral change. The approach incorporates sensitivity to a patient's current "stage of

change” based on the transtheoretical model (Prochaska & DiClemente, 1986), which describes a process of progressing through a series of stages of readiness to engage in behavioral change, including precontemplation, contemplation, preparation, action, and maintenance. MI helps patients move toward positive behavioral change. Originally developed for use in individuals struggling with addictions, MI has been applied in interventions targeting other health populations and incorporated as a core component of a number of interventions targeting treatment and medication adherence among individuals with HIV (e.g., Holstad, DiIorio, & Magowe, 2006; Safren et al., 2009), with promising results regarding improved adherence rates (Golin et al., 2006; Safren et al., 2009). Health care providers can help facilitate behavioral change by maintaining communication with mental health professionals who are providing treatment, thus ensuring consistency and continuity of care. Providers can also facilitate behavioral change by supporting patients in their efforts to engage in HIV risk-reduction behaviors or treatment adherence without imposing judgment.

### Conclusions

CSA is a traumatic experience that may have negative short- and long-term repercussions on the physical and psychological well-being of survivors (Pereda, Guilera, Forns, & Gómez-Benito, 2009). It is crucial for clinicians who treat HIV to screen patients for a history of CSA as this history may have an effect on treatment decisions and adherence to care. Sensitivity to the approach and sensitivity with examinations are important to avoid reintroduction or reenactment of trauma. Women with a history of CSA may respond with a reduction in overall anxiety if the abuse experience is addressed in a sensitive and nonjudgmental manner. Attention to the history of CSA and interventions that integrate mental health and physical care may prevent the unfortunate tragedies that result from the inability of women infected with HIV and with a history of trauma to engage in standard health care services.

### Key Considerations

- There is a continuum of risk for those who experience childhood sexual abuse (CSA), with early abuse leading to later abuse and violence, which in turn increases the risk of behaviors that lead to HIV infection. CSA survivors may have a lifetime history of greater exposure to various traumas, as well as greater levels of mental health symptoms.
- Women who are sexually abused at a young age are at risk for a host of physical health problems and disorders, such as gastrointestinal, urinary, gynecologic, and cardiopulmonary symptoms; obesity; pelvic pain; cancers; heart disease; headaches; generalized pain; and medically unexplained conditions. Anxiety, depression, dissociation, and posttraumatic stress disorder are known psychological sequelae of CSA.
- History-taking and physical examination for all patients should include questions pertaining to childhood sexual experiences as part of a comprehensive sexual history for HIV-infected women.
- Consulting CSA survivors about their experiences with the health care system and inquiring about how medical providers can be more sensitive to their needs may help form a partnership in their care.
- Effective women’s HIV-care programs that address the effects of CSA may help increase the rates of adherence to medication regimens and care visits. The term *trauma-informed services* implies that all staff members who interact with the patient have been trained to be sensitive to trauma-related medical and psychological issues often present in trauma survivors.

### Disclosures

The authors report no real or perceived vested interests that relate to this article that could be construed as a conflict of interest.

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