

## Interpersonal Violence and HIV: The Importance of Trauma-Informed, Universal Responses

Patricia Miller\*

\*Mount Royal University, Calgary, Alberta, Canada.

Received May 23, 2018; Accepted July 20, 2018; Published May 26, 2019

### ABSTRACT

The significance of interpersonal violence (IPV) among those living with HIV has been well established by research undertaken at the Southern Alberta Clinic in Calgary, Alberta. There has been ongoing attention given to the interplay between IPV and HIV, which has led to improved medical care pathways specific to screening and response. Their data reveals the potential risks, specifically physical and sexual harm and emotional suffering, which leads to lack of follow-through with HIV medical care. Social workers, nurses, doctors and psychologists are key clinical team members in service delivery around prevention, intervention, and education in relation to IPV and its impact on HIV patients. As professional service providers begin to appreciate the current trauma-informed knowledge and contemporary understanding of the impacts of IPV in the lives of persons living with HIV, they will be better equipped to reduce the impact of IPV and to promote healing. This will reduce the trans-generational impact of IPV and increase the quality of life for those living with HIV. A trauma-informed lens invites the development of universal best practice, consisting of protocols and strategies that ask specific questions regarding what types of abuse or neglect people have experienced, and when. These relationship-focused questions are key to building new health prevention strategies that will reduce risk factors and increase protective factors when addressing this social epidemic, its impact and its relationship with the co-morbid health issue of HIV.

**Keywords:** Interpersonal violence, HIV Trauma-informed response(s), Universal screening, Stigma, Shame, Epigenetics (risk and protective factors), Vicarious trauma

### INTRODUCTION

In Canada, interpersonal violence (IPV) screening has allowed estimation of the prevalence of IPV in persons living with HIV. Siemieniuk et al. [1] found that patients with a history of IPV are more likely to engage in behaviors that put them at high risk for HIV-infection, such as unprotected sex, sex with multiple partners and intravenous drug use (IDU). They also found that IPV can negatively impact treatment and disease management. The prevalence of abuse among HIV patients was reported to be 35% and was much higher among certain subgroups of patients, such as females, gay/bisexual males and females and Aboriginal Canadians. Aboriginal Canadians had the highest prevalence of reported abuse at 61%. Twenty percent of the 46 patients who reported abuse in their current relationship did not feel safe in their present situation (pp: 764-766). This epidemic of abuse has significant consequences, in part because the effects of the initial trauma may compound over time if the trauma is not properly addressed. Possible psychological risks include chronic despair, avoidance of HIV care and/or partaking in unhealthy behaviors that prevent the patient from engaging in healthy HIV care responses.

The recognition that abuse is a risk factor for poor medical outcomes is pertinent to all HIV medical care centers. Abused patients are more likely to miss appointments or to be lost at follow-up; this creates compounding risk that leads to more hospitalizations, increased risk of life-threatening disease (e.g. AIDS) and a mirage of mental health, addiction, and suicidal concerns [2]. Best practices that incorporate screening of IPV should be engaged to understand the multiple forms of interpersonal violence that patients might have experienced. Engaging a trauma-informed lens invites a safe and caring relationship and can minimize the trauma that may accompany initial conversations between patient

**Corresponding author:** Patricia Miller, MA Psych, R. Provisional Psychologist RSW, MSW, PhD., C. Mediator, The Family Psychology Place Professor, Mount Royal University, Calgary, Alberta, Canada, Tel: 1-403-250-7792; 1-403-801-3642; E-mail: patricia.miller@shaw.ca

**Citation:** Miller P. (2019) Interpersonal Violence and HIV: The Importance of Trauma-Informed, Universal Responses. Int J AIDS, 1(1): 1-5.

**Copyright:** ©2019 Miller P. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

and practitioner. This approach can help practitioners focus on the recognition and delivery of services to address the impact of trauma on the lives of their patients. Ultimately, the initial reduction in the impact of trauma has a cascade effect; it reduces the physical and psychological impact of abuse for patients living with HIV, which further decreases the lack of follow-through and increased hospitalizations that arise from compounding psychiatric issues, other health-related issues or AIDS-defining illnesses.

## TRAUMA-INFORMED CARE

### Universal screening

Trauma can generate its own intelligence by initiating stress responses. Traumatic memories become deeply embedded in people who have been exposed to various forms of abuse to which they have no control over. This new, trauma-driven intelligence, consisting of a primary fight, flight, or freeze response, compromises the ability of affected people to follow-up on appointments, deal with health issues, and/or make choices about their health that align with recommended medical care [3]. To reduce the impact of trauma on the lived experience of people with HIV, it is essential to carry out universal IPV screening, in which all patients who access health services are screened. Universal screening reduces the risk of excluding populations that professionals might deem low-risk for IPV. This type of inadvertent exclusion can be oppressive and stigmatizing, and can arise because of a lack of professional knowledge and bias about risk factors correlated with abuse. Childhood abuse does not necessarily leave physical marks, but its psychological impact creates a lifetime legacy of pain and suffering if not properly addressed. This trauma legacy holds its own intelligence and underpins the avoidance, anger, lack of follow-through, emotional distress and increased chance of mental health crisis in trauma victims – all behaviors that are driven by trauma’s fight, flight, or freeze response.

Universal IPV screening can consist of a pre-determined series of questions that are developed for a clinic, or may consist of a previously developed questionnaire [4]. The Adverse Childhood Experiences (ACE) questionnaire has been the topic of considerable research. This questionnaire asks participants 10 questions related to their childhood experiences, primarily within their family of origin. The ACE questionnaire is unique because it clearly identifies risk factors for abuse. These risk factors can then be addressed through trauma-informed care approaches that nurture the helping relationship and ask patients “what has happened to you?” rather than “what is wrong with you?” These trauma-informed relationship strategies and best practices during trauma assessment can reduce the impact of both past and current trauma. Multiple studies [5-7] have found a correlation between childhood trauma and HIV risk-taking behaviors; trauma victims tend to be more at risk of isolation, mental health issues, and addiction, creating a trajectory of pain and suffering. Universal screening

provides an opportunity to immediately identify trauma and its impact, and to address quality of life issues. This creates a collaborative and caring relationship between the patient and practitioner in which HIV patients can self-determine their healing needs.

## A CARING RELATIONSHIP

### A universal need

The value of a caring relationship between patient and practitioner is well-supported by evidence. A warm, interested, validating therapeutic alliance is influential and facilitates positive patient-professional working relationship outcomes, leading to the implementation of theoretical frameworks, professional discipline, or specific counselling techniques [8-10]. In trauma-informed best practice applications, a caring relationship is mandatory to all screening tools that are implemented by health care staff. This simple requirement is not necessarily easy to deliver; professionals must multi-task and in doing so provide excellent medical care while addressing the unique burden of those impacted by trauma, health crisis, and chronic illness. This relational component of trauma-informed practice is significant and must be situated within an empathetic and understanding relationship. The relationship must also recognize the diversity within the HIV lived experience – age, race, class, sexual orientation, lifestyle engagement and ability – and acknowledge that each person’s experience is unique and important.

Many medical practitioners find that a caring relationship is a powerful clinical practice tool amidst the time constraints that arise from treatment of the complex medical issues that co-exist with HIV. By inviting HIV patients to talk about their trauma and lived experience, a caring relationship can bridge the isolation and discrimination – and thereby reduce the shame and stigma – that accompanies the disease [11]. This trauma-informed response is initiated at the inception of a non-judgmental relationship, and empowers the patient to be ready to accept a universal screening tool as the next step to better understanding their trauma story. This trauma-informed practice stance is response-based. It aligns with contemporary medical practice, which seeks to reduce the burden of trauma across the lifespan of patients as they live with the co-morbidity of HIV and other concurring health issues.

## BEST PRACTICE

### Trauma-informed intelligence in service delivery

The following are roles and activities that trauma-informed practitioners can incorporate into their best practices when dealing with victims of abuse:

- The initial contact person can foster a safe, non-judgmental relationship that allows for initial trust building; they can do so by determining whether or not a person needs to sit in a certain space, whether they

need a support person and whether they are they comfortable;

- Once the practitioner has established a safe space and safe guidelines for the patient, they can engage with empathy, asking safe questions that invite dialogue around “what has happened to you” versus “what is wrong with you”;
- Participation in engaged and validating relational dialogues that invite an ongoing understanding of core trauma experiences of the patient and seek to understand the patient’s lived experience with HIV as well as the co-morbidity of trauma;
- Implementation of the ACE screening tool, an alternative trauma-sensitive, IPV screening tool or a series of questions that creates a generative dialogue that allows the practitioner to gain an understanding of the patient’s experience with different types of abuse and how this abuse might have affected different relationships across the patient’s lifespan;
- Collaborative development of short-term, trauma-informed practice response(s) that involve immediate emotional support, including the use of empathy, affirmation of the patient’s emotional suffering, asking the patient “if they want to continue” while encouraging them to continue if there is an immediate safety concern that must be addressed and engaging a soothing therapeutic response with compassionate inquiry to further support more understanding and response;
- Longer-term, collaborative, trauma-informed practice response(s) that include ongoing support through a therapeutic relationship that focuses on supporting healing. Therapy might include individual therapy, group therapy and/or family therapy, equine therapy, art therapy – all within the realm of trauma-informed treatment planning;
- Co-empowerment of the client to have a sense of self-determination in relation to systemic and structural oppression that might exist and create barriers as they seek to access the recommended trauma care (e.g. financial limitations, location of resources, lack of transparent processes, legal processes that are complex, the need to lay charges against the abuser);
- On-going facilitation of counseling with the patient to empower them to establish healthier, longer-term relationships, which can include follow-up on therapy processes, seeking understanding of ongoing systemic barriers and co-creating other trauma-informed responses around mental health and addiction concerns that might co-exist with the original trauma;
- Educating and collaborating with other professionals on the multi-disciplinary health care team to facilitate a psycho-educational understanding of trauma, how it might impact patients across their lifespan and how defense mechanisms might arise from the HIV patient feeling that they cannot trust their medical practitioner to provide a safe, non-judgmental, and caring relationship;
- Development of peer-support and peer-navigation processes that engage those who have established a sense of self-determination in their healing and can act as leaders of change for others. The readiness of these leaders to guide other patients becomes evident once their primary trauma has been recognized and has healed enough to allow the patient to engage in peer-related friendships;
- Seeking to align peer-support and peer-navigation within Indigenous populations by engaging elders as cultural-leaders in Indigenous communities that are seeking to develop culturally, appropriate services for Indigenous persons living with HIV;
- Collaborating with cultural communities and leaders to ensure that trauma-informed practice strategies are congruent with the cultural needs of the communities, while recognizing that non-verbal communication (e.g. facial expressions such as eye contact, sighs, covering face, looking away, body position) should be considered when trying to build safe and trusting relationships;
- Aligning trauma-informed practices with cultural-religious values and beliefs. This might require an understanding of how family systems and the roles of family members are developed, and how this can contribute to the acceptance of various types of controlling behaviors that might not be acceptable within a trauma-informed stance;
- Collaborative understanding of the role of spirituality in trauma-informed healing practices within Indigenous communities. An understanding of intergenerational trauma-healing practices requires a recognition of how Indigenous communities collectively empower themselves through their cultural practices and ceremonies, including healing lodges, prayer and sharing circles, smudging, medicine people, elder guidance, pow wow dancing and sundance;
- Being a catalyst for systemic changes, including formal discussions around trauma-informed care, its application, the ongoing support needed to implement care and the staff support needed to deal with the impact of burnout and vicarious trauma;
- Advocating for staff retreats, counseling and ongoing supervision of trauma-informed practices for staff that may become traumatized themselves by hearing the traumatic stories of others. This vicarious trauma has underpinnings in exposure to hearing about the

dominance and submission experiences that perversely invade the lives innocent of HIV patients. For patients, these experiences cause substantial shame and suffering amidst the stigma and isolation of trauma and HIV.

The ongoing implementation of trauma-informed care responses can be integrated into formal primary care pathways, which include the best practice application of universal screening for all patients living with HIV [12]. Multiple studies have found that immediate intervention with a trauma-informed care lens is an important preventative strategy for those who have had traumatic experiences [13-16]. It is important to provide ongoing therapeutic support across a patient's lifespan while at the same time triaging primary crisis responses. These crisis responses might include trauma therapy; mental health and addiction crisis responses; legal, financial and educational support; child and family services; and other health-related supports. Wrap-around care maybe available. However, when it is not available due to a lack of resources, a clear case management plan should be put in place that empowers the client to understand the steps that they can take to support their own crisis management and achieve self-determination. When an HIV patient is not properly supported, they may perceive that their medical practitioner is being dismissive and is diminishing the significance of their trauma. This perceived lack of understanding, especially in cases of psychological abuse or neglect, can re-victimize a patient. This re-victimization of the HIV patient can lead to secondary trauma (a sense of not having control, being misunderstood, feeling isolated, lacking authority for decision-making), which can compound the experience of the primary trauma, leaving the HIV patient feeling more helpless, less validated and further stigmatized.

## CONCLUSION

Trauma-informed practice for professionals in health care settings, specific to HIV and IPV, is part of primary intervention. As part of the multidisciplinary team, trauma-informed best practice principles provide the short- and longer-term support that is needed for HIV patients who face the contemporary issues of stigma, violence, shame, and comorbidities that merge trauma with mental health issues, addictions, and other chronic, stress-related illnesses. Having trauma validated as real and worthy of recognition is core to the initial trauma-focused engagement; facilitating patient awareness of the impact of IPV breaks down the shame and isolation that comes with it. Education around the support systems that may be required (e.g. justice, policing, safe shelters) is essential to the intake work that begins the healing process for persons living with HIV. Capacity-building work follows, which includes co-empowerment aimed at bridging isolation and engaging therapeutic resources to help mitigate the impact of IPV, including co-existing mental health issues, addictions, or other health conditions.

A trauma-informed, collaborative helping process in medical environments is pertinent to addressing the impact of IPV on the lives of persons living with HIV. This process can be critical to reducing the burden of trauma and shame. In the context of IPV and HIV, multi-disciplinary team members must be educated in trauma-informed best practice strategies and should actively engage in the application of universal trauma-informed assessment tools within their health care work settings. Finally, ongoing supervision and support for professionals working around trauma-informed practice is essential and mandatory for the well-being of staff, which will accumulate the vicarious-emotional burden of the trauma story. The compassionate-inquiry involved in asking the question "what has happened to you" can precipitate vicarious emotional activation that can lead to burnout and trauma-responses in those who care for others living with HIV.

## REFERENCES

1. Siemieniuk RAC, Krentz HB, Gish JA, Gill M (2010) Domestic violence screening: Prevalence and outcomes in a Canadian HIV population. *AIDS Patient Care STDs* 24: 763-770.
2. Siemieniuk RAC, Miller P, Woodman K, Krentz HB, Gill MJ, et al. (2013) Prevalence, clinical associations and impact of intimate partner violence among HIV-infected day and bisexual men: A population-based study. *HIV Med* 14: 293-302.
3. D'Andrea W, Sharma R, Zelechowski AD, Spinazzola J (2011) Physical health problems after single trauma exposure: When stress takes root in the body. *J Am Psychiatr Nurses Assoc* 17: 378-392.
4. Raissi SE, Krentz HB, Siemieniuk RA, Gill MJ (2015) Implementing an intimate partner violence (IPV) screening protocol in HIV care. *AIDS Patient Care STD* 29: 133-141.
5. Jones DJ, Runyan DK, Lewis T, Litrownik AJ, Black MM, et al. (2010) Trajectories of childhood sexual abuse and early adolescent HIV/AIDS risk behaviors: The role of other maltreatment, witnessed violence and child gender. *J Clin Child Adolesc Psychol* 39: 667-680.
6. Gore-Felton C, Kalichman S, Brondino M, Benotsch E, Cage M, et al. (2006) Childhood sexual abuse and HIV risk among men who have sex with men: Initial test of a conceptual model. *J Fam Violence* 21: 263-270.
7. Wilson HW, Widom C (2011) Pathways from childhood abuse and neglect to HIV-risk sexual behavior in middle adulthood. *J Consult Clin Psychol* 79: 236-246.
8. Miller SD, Hubble MA, Chow DL, Seidel JA (2013) The outcome of psychotherapy: Yesterday, today and tomorrow. *Psychotherapy (Chic)* 50: 88-97.



9. Wampold BE (2010) The research evidence for the common factors models: A historically situated perspective. In Duncan BL, Miller SD, Wampold BE, and Hubble MA (eds.), *The Heart and Soul of Change: Delivering What Works in Therapy*. Washington, DC, US: American Psychological Association, pp: 49-81.
10. Thomilson R (1984) Something works: Evidence from practice effectiveness studies. *Soc Work* 29: 51-56.
11. Harris M, Fallot RD (2001) Designing trauma-informed addiction services. *New Dir Ment Health Serv* 89: 57-73.
12. Todahl J, Walters E (2011) Universal screening for intimate partner violence: A systematic review. *J Marital Fam Ther* 37: 355-369.
13. Curran GM, Pyne J, Fortney JC, Gifford A, Asch SM, et al. (2011) Development and implementation of collaborative care for depression in HIV clinics. *AIDS Care* 23: 1626-1636.
14. Hedtke KA, Ruggiero KJ, Fitzgerald MM, Zinzow HM, Saunders BE, et al. (2008) A longitudinal investigation of interpersonal violence in relation to mental health and substance use. *J Consult Clin Psychol* 76: 633-647.
15. Olisah V, Baiyewu O, Sheikh T (2011) Depression under diagnosis and the effects on quality of life in outpatients with HIV at a Nigerian university teaching hospital. *Afr J AIDS Res* 10: 247-254.
16. Gupta R, Dandu M, Packel L, Rutherford G, Leiter K, et al. (2010) Depression and HIV in Botswana: A population-based study on gender-specific socioeconomic and behavioral correlates. *PLoS One* 5: 1-9.