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Why Care for People Living with HIV May Work Best If Trauma Risks are Considered

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Trauma is defined by the Substance Abuse and Mental Health Services Administration as events or circumstances that are "experienced by an individual as physically or emotionally harmful or life-threatening and that [have] lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing." Trauma is common among people infected with the human immodeficiency virus – called HIV. This infection, like other distressing and life-threatening events, can prompt anxiety and lower self-efficacy, further undermining health and people's ability to recover. Health providers need to understand the risks of trauma as they treat people with HIV.

Programs that acknowledge and address trauma along with mental health issues and substance abuse have been shown to deliver better care and result in better health outcomes among their patients. Unfortunately, trauma-informed care to improve HIV outcomes is not yet well established, and has only been recommended to treat HIV-infected women who are widely acknowledged often to be victims of gender-based violence. But what about other populations? Our research indicates that understanding of trauma risks is important to the successful treatment of many vulnerable groups of HIV patients, including men who have sex with men and transgender people.

Histories of Trauma Often Underlie HIV Infections

Trauma is common among HIV-infected people. In fact, in the United States, studies have found that nearly 1 in 3 HIV-infected people experienced childhood physical or sexual abuse before age 13, and as many as two thirds to 95% of HIV-infected women, men, and transgender people have experienced intimate partner violence. Among HIV-infected individuals, experiences of trauma are associated with poor mental health, and increased engagement in harmful behaviors like substance abuse and high-risk sexual activity that put others at risk of contracting the virus. HIV-positive people who have experienced trauma are also less likely to follow instructions for HIV care and antiretroviral therapy, and are more likely to suffer from opportunistic infections – or even die. Among people without HIV, trauma survivors are also more likely to become newly infected with HIV, especially if they are also poor or members of minority racial, ethnic, or sexual identity groups.

Mutually reinforcing risks from trauma and HIV infections underscore the need for interventions to address trauma and its associated consequences in order to improve the physical and mental wellbeing of HIV patients and their chances for successful treatment and recovery. Healthcare providers are increasingly aware of the ways trauma and HIV infections interact, and researchers are developing better interventions to deal with both risks together. However, much work remains to be done.

Different Populations with Different Traumas Should Not be Excluded

Calls for a trauma-informed care in HIV programs (prevention and treatment) have focused almost exclusively on women and girls, and have primarily focused on trauma due to childhood abuse and intimate partner violence. This is a promising start, but trauma isn't just a women's issue. Men and transgender people also experience staggering rates of trauma, making trauma-informed approaches to their HIV care equally necessary.

Traumatic risks come in many forms, not just from interpersonal violence deleterious to people's physical and mental health. Social conditions can also cause traumatic suffering – including conditions such as neighborhood violence or violence based on race or sexual identity or orientation. Treatment and prevention of HIV infections can be enhanced significantly if carried through in tandem with community-directed interventions to reduce such sources of violence.

Promising Next Steps

The magnitude of trauma experienced by populations living with or at risk for HIV – groups such as minority women, men who have sex with men, and injection drug users – suggests the need for community-focused and organizational interventions. Promising research and programming suggest the way forward:

- Programs that build social ties within communities and promote cultural strengths, restorative justice, and resiliency may help address collective trauma and lead to improved health outcomes.
- Medical school curricula should include information on trauma and its impact on health. Healthcare providers should be trained to take comprehensive sexual histories that also capture traumatic experiences their patients may have faced. Such histories, coupled with training, prepare healthcare professionals to identify and offer appropriate supports and social service referrals along with medical treatments.
- Trauma should be acknowledged and addressed in all HIV prevention efforts. Promising efforts in this area include incorporating awareness of trauma into school-based sexual education and teen pregnancy prevention programs.
- Trauma-informed HIV prevention programs and services should be provided within settings that serve adolescents who disproportionately experience traumas – settings such as juvenile justice institutions, foster care services, and agencies serving homeless youth.

As efforts continue to prevent and reduce HIV infections and deaths, addressing trauma remains a clear arena for further innovation and intervention. More research is vitally needed to test the efficacy of healthcare approaches and programs that proceed with an awareness of trauma risks. Do such well-informed and comprehensive efforts do a better job of treating and preventing HIV infections? Evidence to date suggests that the answer is yes, but much more remains to be discovered – especially about what works best for meeting the trauma-related needs of the diverse groups of people most heavily impacted by HIV in the United States.

Read more in Jessica M. Sales, Andrea Swartzendruber, and Ashley L. Phillips, "Trauma-Informed HIV Prevention and Treatment." *Current HIV/AIDS Reports* 13, no. 6 (2016): 374-382.