

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

Patricia Miller\*

Mount Royal University, Calgary, Alberta, Canada

## Abstract

The purpose of this paper is to illustrate how professional service providers must understand the current trauma-informed knowledge and contemporary understanding of the impact of interpersonal violence in the lives of persons living with HIV. If they do, there will be less impact and more healing regarding trauma, its trans-generational impact and increased quality of life for those living with HIV. In addition, a trauma-informed lens invites there to be a development of universal best practice, consisting of protocol and strategies that ask specific questions regarding what types of abuse or neglect people have experienced and when. This paper offers a theoretical framework, while matching relationship-focused questions as key to building new health prevention strategies that will reduce risk factors and increase the protective factors, when addressing this social epidemic called interpersonal violence, its impact and relationship, with the co-morbid health issue of HIV.

**Keywords:** Interpersonal violence; HIV; Trauma-informed response(s); Universal screening; Stigma; Shame; Epigenetics; Vicarious trauma

## Introduction

In Canada, research has been undertaken in regards to interpersonal violence screening which helped to define its prevalence. Siemieniuk et al. discussed how the collected data that shows that the patients with a history of IPV are more likely to engage in high-risk behaviors for HIV-infection, such as unprotected sex and sex with multiple partners, and intravenous drug use IDU (Indoor unit), the data also indicates IPV negatively impacts treatment and disease management, as well. Siemieniuk et al. note that the prevalence of abuse among HIV patients was reported as being 35% and was much higher among certain sub-groups of patients such a females, gay/bisexual (male/female) and Aboriginal Canadians with the highest prevalence of reported abuse (61%) and 20% of 46 patients reporting abuse in their current relationship did not feel safe in their present situation. This epidemic of IPV as noted by Siemieniuk et al. has significant consequences, due to the compounding effect and concurring risk that the initial trauma, if not properly addressed will psychological contribute to chronic despair, avoidance and/or engagement of unhealthy behaviors that can prevent the patient from good HIV care responses [1].

The recognition of abuse as a risk factor in relation to medical outcomes becomes pertinent in all HIV medical care centers; these patients were more likely to miss appointments and be lost-to-follow-up for extended periods with compounding risk that leads to more hospitalizations and in some circumstances to life-threatening disease (AIDS) and a mirage of mental health, addiction and compounding suicidal concerns [2]. Best practice that engages screening of IPV needs to be engaged in order to understand the multiple forms of interpersonal violence that patients might have experienced. Engaging a trauma-informed lens that invites a safe and caring relationship that focuses on reducing the impact of trauma in the initial conversations, helps practitioners focus on recognition and delivery of services to address the impact of trauma on peoples lives. Ultimately, the reduction of the impact of trauma has a cascade effect as 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 from compounding psychiatric or other-health related issues or AID defining illnesses.

## Trauma-Informed Care: Universal Screening

Trauma itself has its own intelligence as it formulates stress responses, due to the encoding of trauma memories that develop from people, being exposed to abuse in various forms that they had no control over. This new trauma-driven intelligence consisting of primary fight, flight or freeze responses, compromises people's abilities to follow-up on appointments, deal with health issues and/or make choices that would be healthier for them in relation to their medical care as identified by D'Andrea et al. [3]. The use of universal screening, where all patients who access health services are screened in a respectful way is absolutely essential, when considering how to reduce the impact of trauma on the lived experience of those, living with HIV. Universal screening helps reduce the risk of excluding populations that professionals might deem as not at risk for interpersonal violence, which can be oppressive and stigmatizing, due to lack of professional knowledge and bias about risk factors correlated with abuse. Childhood abuse does not necessarily leave physical marks; its impact psychologically leaves a lifetime legacy of pain and suffering, if not given a chance to be healed. This trauma legacy holds its own intelligence as it underpins the avoidance, anger, lack of follow through, emotional distress, increased mental health crisis that fight, flight or freeze responses represent.

Universal screening can be a pre-determined series of questions that are developed for a clinic or a previously developed questionnaire [4]. There is also significant research developed around the ACE questionnaire (adverse childhood experiences), which asks participants 10 questions related to their childhood experiences, primarily within their family of origin. The uniqueness of the ACE questionnaire is that it

\*Corresponding author: Patricia Miller, Professor, Social Work, Mount Royal University, 4825 Mount Royal Gate SW, Calgary, Alberta T3E 6K6, Canada, Tel: 14038013642; E-mail: [patricia.miller@shaw.ca](mailto:patricia.miller@shaw.ca)

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clearly identifies risk factors, which can be addressed through trauma-informed care approaches such as further developing the helping relationship and asking patients, “what has happened to you”? versus “what is wrong with you”? These significant steps in developing new trauma-informed relationship strategies and best practice responses can reduce the impact of trauma both past and current, when trauma-informed relational strategies are employed around assessing trauma. Multiple studies [5-7] identify how the correlation between childhood trauma and HIV risk taking behaviors; with increased risk of isolation and mental health and addiction concerns within the trajectory of pain and suffering. Universal screening can give an opportunity for quality of life issues to be addressed through immediate identification of the trauma, its impact and a response that is collaborative as HIV patients seek to self-determine their healing needs, within a caring professional relationship.

### A Caring Relationship: A Universal Need

The value of a caring relationship is well understood as research literature indicates that a warm, interested, validating therapeutic alliance is more influential as a protective factor in facilitating positive patient- professional working relationship outcomes, then theoretical framework, professional discipline, or specific counseling 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 as professionals, multi-task and provide the excellence of medical service that is expected, within the burden of caring for those, impacted by trauma, health crisis and chronic illness. This relational component of trauma-informed practice is significant and one that must be situated, within an empathetic and understanding relationship that holds all diversity of age, race, class, sexual orientation, lifestyle engagement, ability and all other unique characteristics of the HIV lived experience as unique and important.

At times, the only consistent practice tool that medical practitioners will have is a caring relationship, amidst the time constraints of the treatment of complex medical issues that co-exist with HIV. In order to reduce the shame and stigma that co-exists with HIV a caring relationship can bridge isolation and discrimination by inviting HIV patients to talk about their trauma and lived experience [11]. This trauma-informed response is initiated within the inception of non-judgmental relationships, seeking to co-empower the patient into being ready to accept a universal screening tool as a next step to better understanding their trauma story. This trauma-informed practice stance is response-based and aligns with contemporary medical practice that seeks to reduce the burden of trauma across the lifespan as patients live with the co-morbidity of HIV, and other concurring health issues.

### Best Practice: Trauma-Informed Intelligence in Service Delivery

The role that trauma-informed practitioners can facilitate in their best practice implementation as follows:

The initial contact person can provide a safe, non-judgmental relationship that allows for the initial trust building which includes decisions on whether or not people need to sit in a certain space, do they need a support person, are they comfortable.

Establishing safe questions that invite dialogue around “what has happened to you” versus “what is wrong with you” would be engaged with empathy, once the practitioner has established a safe space, with safe guidelines for the patient.

Engaged and validating relational dialogues that invite ongoing understanding of core trauma experiences and seek to understand the lived experience of the person living with HIV and the co-morbidity of trauma.

Implementation of ACE (Adverse Childhood Experiences) screening tool or another trauma-sensitive, interpersonal violence screening tool or a series of questions that would allow for a generative dialogue on a definition of the different types of abuse, what they are, how they might look in different relationships across the lifespan and whether or not that person has experienced them.

Collaborative development of short-term trauma-informed practice response(s) that include immediate support emotionally including the use of empathy, affirmation of the emotional suffering, asking the patient “if they want to continue”, though encouraging them to continue if there is an immediate safety concern that needs to be addressed and engaging a soothing therapeutic response with compassionate-inquiry to further support more understanding and response.

Collaborative longer-term, trauma-informed practice response(s) that include ongoing support through a therapeutic relationship with a focus on supporting healing that 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 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 such as financial limitations, location of resources, lack of transparent processes, legal process that are complex, if there is a pertinent need to charge the abuser.

On-going facilitation of counseling with the patient in order 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 psycho-educational understanding of what is trauma, how might it impact patients across the lifespan and how might defense mechanisms appear in relation to the HIV patient not feeling like they can 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 are able to be leaders in change for others as their readiness to guide other patients becomes evident once the primary trauma has been recognized and is healed enough to allow the patient to engage peer-related friendships.

Seeking to align peer-support and peer-navigation within Indigenous populations by engaging the use of 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 make sure that trauma-informed practice strategies are congruent with the cultural needs of the communities, while recognizing non-verbal communication needs to be considered when trying to build safe and trusting relationships considering facial expressions such as eye contact, sighs, covering face, looking away, how people hold their body position to name a few.

Aligning trauma-informed practices, with cultural-religious values/beliefs which might require an understanding of how family systems and roles of family members are developed which can contribute to acceptance of various types of controlling behaviors that might not be considered okay within a trauma-informed stance.

Collaborative understanding of the role of spirituality in trauma-informed healing practices that Indigenous communities interplay, with intergenerational trauma-healing that requires recognition of how Indigenous communities, collectively empower themselves through their cultural practices and ceremonies that include healing lodges, prayer and sharing circles, smudging, medicine people, elder guidance, pow wow dancing, and Sundance.

Being a catalyst for systemic changes that include formal discussions regarding trauma-informed care, its application, the ongoing support needed to implement care and lastly, the staff support needed in order to deal with the impact of burnout and vicarious trauma.

Advocating for staff retreats, counseling and ongoing supervision of trauma informed practices as staff hears and receives the details of horrific trauma stories that can burden HIV practitioners, due to vicarious trauma, its underpinnings of exposure to hearing dominance and submission experiences that perversely invade the innocent of HIV patients lives (past and present), while causing 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]. Immediate intervention with a trauma-informed care lens might be an important preventative strategy for those whom have experienced traumatic experiences, as recognized by multiple studies [13-16]. It's important to have ongoing therapeutic support across the lifespan, while triaging primary crisis responses, which includes trauma-therapy, mental health and addiction crisis response, legal, financial and educational support, child and family services and other-health related supports. Wrap around care maybe available, due to a limitation of resources, if not then a clear case management plan that seeks to co-empower the client to understand the steps taken by themselves and others supporting them in the process is part of patient self-determination. The lack of support for the HIV patient, while in a medical process can look like a practitioner being dismissive to the significance of the persons trauma story, not seeking to understand the trauma, focusing on time versus space for the story, minimizing the type of abuse, especially the impact 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 having no control, not being understood in the process, isolation in the process and lack of authority over decisions made) can compound the experience of the primary trauma, while leaving the HIV patient feelings 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 members of the multidisciplinary team, trauma-informed best practice principles provide needed short-term and longer-term support for HIV patients facing contemporary issues of stigma, violence, shame and co-morbidities that merge trauma with mental health and addictions and other chronic, stress-related illnesses. Having trauma validated as real and worthy of recognition is core to initial trauma-focused engagement;

facilitating patient awareness to the impact of interpersonal violence breaks down shame and isolation; educating them on the support systems that may be required (e.g., justice, policing, safe shelters) is essential to inception work that begins the healing process for persons living with HIV. Then capacity building with the HIV patient includes co-empowerment that bridges isolation and engages therapeutic resources to help mitigate the impact of IPV; while mediating the co-morbidity of mental health, addictions and other health conditions that co-exists with IPV.

A trauma-informed, collaborative helping process in medical environments is pertinent to addressing the impact of IPV on the lives of person's living with HIV while reducing the burden of trauma and shame. Multi-disciplinary team members in the context of IPV and HIV must be educated in trauma-informed best practice strategies, and actively engaged 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, who will accumulate the vicarious-emotional burden of the trauma story. The compassionate-inquiry involved in asking the question(s) of "what has happened to you" can precipitate vicarious emotional activation that contributes to burnout and trauma-responses in those, who care for those, who deserve to be cared about when living with HIV.

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