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Invited paper

Violence Prevention among HIV-Positive Women with Histories of Violence: Healing Women in Their Communities

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A B S T R A C T

Experiences of past and current gender-based violence are common among HIV-positive women in the United States, who are predominantly from ethnic minority groups. However, culturally congruent, feasible interventions for HIV-positive women who have experienced past and/or current violence are not widely available. The Office on Women's Health Gender Forum has made several recommendations for responding to the National HIV/AIDS Strategy Implementation Plan, including recommendations to incorporate gender-based violence prevention into a comprehensive, gender-responsive national strategy. This paper draws on an example of a community-based project for HIV-positive women, the Healing Our Women Project, to illustrate how violence prevention can be achieved within peer-led and community-based programming. Strong community partnerships, responsiveness to community needs and local cultural norms, a trained workforce, and culturally competent care are programmatic cornerstones of gender-responsive services. HIV-positive women with histories of gender-based violence and risk factors for current and future violence deserve the highest quality gender-responsive services to ensure that they can address their health needs within contexts of safety and respect.

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Introduction

Gender-based violence against girls and women, including intimate partner violence and child sexual abuse, is common in American society, and this violence begets further violence. According to the National Center for Injury Prevention and Control, women experience about 4.8 million intimate partner-related physical assaults and rapes every year (Tjaden & Thoennes, 2006). Intimate partner violence can have lasting effects on the health and well-being of women in today's society (Becker, Stuewig, & McCloskey, 2010; Jordan, Campbell, & Follingstad, 2010). Several studies have demonstrated that intimate partner violence increases risk for HIV infection: One in two HIV-positive women has a history of sexual and/or interpersonal violence compared with one in three HIV-negative women with similar histories (Wyatt et al., 2002).

The relationship between a history of sexual violence (e.g., child sexual abuse) and later sexual risk taking has been empirically demonstrated both domestically and internationally (Chin, Wyatt, Carmona, Loeb, & Myers, 2004; El-Bassel, Gilbert, Witte, Wu, & Chang, 2011; Fuentes, 2008; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2007). This relationship likely contributes significantly to the higher prevalence of HIV among women with histories of sexual or intimate partner violence (Campbell et al., 2008; Cavanaugh & Classen, 2009; Raj, Reed, Welles, Santana, &

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Silverman, 2008; Sareen, Pagura, & Grant, 2009; Wilson & Widom, 2008), which further contributes to numerous health and psychosocial problems, substance abuse, psychological disorders, poor HIV medication adherence, and a poorer quality of life (Gielen et al., 2007; McDonnell, Gielen, O'Campo, & Burke, 2005; Meade, Hansen, Kochman, & Sikkema, 2009; Pence, 2009). Intimate partner violence may be more common among ethnic minority couples than White couples (Field & Caetano, 2003), resulting in these sequelae being of even more concern among ethnic minority women (West, 2004). Identification of those most vulnerable to gender-based violence and associated deleterious health risk behaviors is a high priority and is critical to prevention efforts on international, national, state, community, and neighborhood levels (Abramsky et al., 2011).

Given that HIV disproportionately affects ethnic minority and low-income women (Centers for Disease Control and Prevention, 2010), interventions that address both HIV infection and violence (both past and current) among ethnic minority women are urgently needed to minimize their risk behaviors and mental health needs. However, as noted in the Office on Women's Health (OWH) Gender Forum Recommendations, gender-based violence is not a distinct part of the National HIV/AIDS Strategy Implementation Plan. Therefore, violence prevention components of HIV treatments are marginal, if they are even present at all. Considering the evidence presented, we contend that gender-based violence must receive considerable attention within comprehensive gender-responsive services for both HIV-positive and -negative women in the United States, with particular attention to violence against ethnic minority women.

In an effort to develop services for communities that have no violence prevention programs, we engaged in a National Institute of Mental Health-funded randomized controlled trial that examined the efficacy of a trauma-focused intervention to improve mental health among HIV-positive ethnic minority women (Table 1).

This paper highlights successes and challenges in, and implications of, our study of 147 HIV-positive African-American and Latina women with histories of sexual abuse and violence, including 63% who reported vaginal rape by a family member before age 18 (Table 2).

The goals of the "Healing Our Women" (HOW) Project were to 1) reduce psychological symptoms including depression, posttraumatic stress disorder (PTSD), and sexual trauma symptoms (e.g., unwanted sexual thoughts or feelings; Myers, et al., 2006; Briere, Elliott, Harris, & Cotman, 2003; see Table 3 for outcome measures); 2) address gender, culture, and the context of sexual risk taking (Raj, Silverman, & Amaro, 2004; Wyatt, 1994); and 3) achieve the above in partnership with community-based organizations (CBOs) that have limited training, staff shortages, and high turnover (Veniegas, Kao, Rosales, & Arellanes, 2009). There was recognition throughout the project that participants were likely to have experienced multiple forms of violence in their lives, so we considered violence prevention (i.e., prevention of revictimization, or secondary prevention) to be an inherent theme in the project.

These goals are consistent with several of the OWH Forum recommendations and a large-scale synthesis of the evidence on "what works" in HIV programming for women and girls (Gay et al., 2010; Table 4). The intervention used in the HOW Project was the Enhanced Sexual Health Intervention (ESHI).

Table 1
The Healing Our Women Project

Utilized a quasi-experimental randomized controlled trial design.
Tested efficacy of the ESHI, an 11-session, gender-specific and culturally congruent intervention, compared with a wait list condition.
Examined condom use, HIV medication adherence (Wyatt et al., 2004), and symptoms of posttraumatic stress disorder and psychological distress.
Provided the intervention to HIV-positive African American and Latina women with child sexual abuse histories.
Involved peer-facilitated sessions with weekly trauma writing in journals (Pennebaker, 1997).
Assessed efficacy of the ESHI in the context of community-based organizations that serve HIV-positive women.
Involved local experts and stakeholders in implementation.

Abbreviation: ESHI, Enhanced Sexual Health Intervention.

Table 2
Sample Characteristics

Mean age (yrs)	39
High school diploma	56%
Not working outside the home	93%
Dating, married, or living with a partner	70%
Lived with HIV (average)	7 years
AIDS diagnosis	13%
Vaginal rape by a family member before age 18	63%

Implementation Challenges of Violence Prevention Programs

Implementing violence prevention programs in community-based settings requires many compromises, especially when evaluation is involved. In the HOW Project, to meet the needs of women who were seeking services for the first time, we utilized a quasi-experimental, wait list design: All women who consented to participate would receive the intervention—some immediately, and some (the wait list group) after waiting 3 months (Table 5).

Table 3
HOW Project Analysis, Outcome Measures, and Findings

Analysis
Used a growth modeling strategy to examine the effects of multifaceted intervention data collected at multiple time points (Duncan, Duncan, Strycker, Li, & Alpert, 1999; Wang, Siegal, Falck, Carlson, & Rahman, 1999).
Maximum likelihood allowed for investigation of the rate of change in outcomes across time.
For PTSD and psychological distress variables, sexual trauma symptoms were included as an explanatory variable, and for the psychological distress analysis, PTSD was included as a predictor.
Outcome measures and findings
PTSD symptoms
Measured with PTSD diagnostic module of the Composite International Diagnostic Interview (Kessler et al., 1994).
Women who participated in the ESHI reported the largest reduction in PTSD symptoms at posttest (i.e., directly after the intervention; $p < .05$).
PTSD symptoms declined while women were waiting for the intervention ($p < .05$), more for the wait list group than the case management group ($p < .05$).
Women who had reduced PTSD symptoms also had reduced psychological distress (i.e., depression and anxiety; $p < .01$).
Psychological distress
Measured depression with the Center for Epidemiological Studies-Depression Scale, and anxiety with the Symptom Checklist-90-Revised anxiety subscale.
Sexual trauma symptoms
Measured with Trauma Symptom Inventory Sexual Concerns subscale (Briere et al., 1995).
Sexual symptoms decreased over time for all women who entered the study ($p < .05$).

Abbreviation: PTSD, posttraumatic stress disorder.

Table 4
Addressing "What Works" (Gay et al., 2010) and Agency Requests in the HOW Project

Core Requests From the Agencies	Responses in the HOW Project	Corresponding Recommendations From "What Works for Women and Girls"
Address risky sexual behaviors and mental health problems through integrated services.	Utilized integrative approach to reduce trauma-related symptoms, sexual risk behavior, psychological distress, and sexual trauma.	Integrated programming can be ideal. Meeting women's sexual and reproductive health needs will impact the HIV epidemic.
Provide an intervention that is gender-specific and culturally congruent; make the intervention available to all women.	Core elements piloted, curriculum provided in English and Spanish for African-American and Latina women. Transportation offered.	Women are diverse and need diverse programming.
Provide ongoing treatment, especially for PTSD and psychological distress,	See Table 3 for project details.	Treatment works.
Anticipate that dropouts will come back.	Designed study to examine effect of waiting for treatment and to allow participants to return and receive make-up sessions.	Prevention is key.
Use a peer support model.	A buddy system encouraged attendance, retention, and secondary prevention.	Women need more support—especially from their peers.
Train staff in trauma and HIV; anticipate that staff turnover could limit sustainability.	Provided extensive training and supervisor debriefing for trauma-related service staff; made retraining available at agency by in-house staff.	Strengthening the enabling environment is an urgent priority (including training providers).

Abbreviation: PTSD, posttraumatic stress disorder.

During the study, the original wait list condition split into two conditions: Women who chose to participate in the intervention after the 3-month waiting period, and women who chose not to participate when the waiting period was over. The former became the waiting list group and the latter were identified as the case management group because they chose to receive only case management services and declined the intervention. This resulted in challenges from an empirical point of view, but it also represented an opportunity to conduct innovative analyses and to gain "real-life" insights into the efficacy of the intervention (Alegría, 2009; Hohmann & Shear, 2002). Furthermore, this accommodation is responsive to the OWH Forum recommendations, by demonstrating an ability to retain participation of women, according to their preferences, even if, as in this study, those preferences conflict with a research design.

Table 5
Recruitment and Screening

Recruitment
- Flyers were placed in CBOs, AIDS service organizations, and drug rehabilitation centers in Los Angeles County

Eligibility
- Born female
- Self-identified as African American, Latina, or European American
- 18 years of age or older
- HIV-positive (confirmed)
- Positive child sexual abuse history (i.e., endorsing at least one screening question)
  - A child sexual abuse history was defined as incidents occurring before the age of 18 that involved coercion or violence (see below for screening questions)

Screening questions
- To assess child sexual abuse history, women were screened face-to-face on nine questions from the Wyatt Sexual History Questionnaire (Wyatt, 1985). In answering these questions, women were asked to recall experiences with an adult or someone older than them, including relatives, friends, or strangers.
  1. Before you were 18, did anyone put their penis in your vagina?
  2. Before you were 18, did anyone attempt to put their penis in your vagina?
  3. Before you were 18, did anyone force you to lick or such their vagina?
  4. Before you were 18, did anyone ever put their penis in your mouth or put their mouth on your vagina or labia?
  5. Before you were 18, did anyone put their finger or an object in your vagina?
  6. Before you were 18, did anyone attempt to put their finger or an object in your vagina?
  7. Before you were 18, did anyone force you to put your finger or an object in their vagina?
  8. Before you were 18, did anyone ever put their penis in your bottom, behind, or butt?
  9. Before you were 18, did anyone attempt to put their penis in your bottom, behind, or butt?

Abbreviations: CBO, community-based organization.

Secondary Violence Prevention: The ESHI

The ESHI is guided by cognitive-behavioral approaches to safer sex behaviors using culture- and gender-specific concepts commonly promoted within families and religious teachings of ethnic minority women. The curriculum highlights three culturally related themes: 1) Interconnectedness, 2) body awareness, and 3) sexual ownership (Wyatt, 2009). These themes were piloted with African Americans and Latinas to ensure that they represented cultural, gender-based, and religious perspectives of these groups; in addition, the concepts in the intervention were discussed by experts from relevant cultural backgrounds in order to establish and validate the cultural congruency of the curriculum. In the ESHI, HIV skills are taught within the context of these themes so that women can acknowledge and reframe any cultural and religious messages that could hamper HIV prevention efforts (Chin et al., 2004). The themes are embedded in six core elements: 1) Disclosure of childhood sexual abuse and trauma is central to making the link between childhood sexual abuse and HIV (sexual ownership); 2) emotional and cognitive processing of trauma reduces the effects of trauma (body awareness); 3) making the link between emotions and behavior reduces risk and revictimization (sexual ownership); 4) coping and resilience maintain health and well-being (interconnectedness); 5) awareness of culture, gender, and spiritual beliefs enhances well-being (interconnectedness); and 6) ongoing monitoring of trauma and mental health minimizes the lasting effects of sexual risk taking (body awareness).

The intervention focuses on the sexual histories of participants and links from those histories to current cognitive, affective, and behavioral patterns and circumstances, including intimate partner violence. The impact of sexual and physical abuse on personal decision making is emphasized throughout the sessions as an important connection between past violence, HIV infection, and current functioning. To help women recognize

and avoid current and/or future unhealthy relationships and behaviors, they engage in group problem-solving activities using hypothetical scenarios. For example, one group exercise required women to identify healthy and unhealthy behaviors, people, and situations. The exercise sharpened women's skills in identifying risks that are sometimes hidden, and reinforced strategies to avoid them. Throughout the intervention, women are given referrals to appropriate individual, couples, or group therapy, or to primary care for medical issues related to sexually transmitted infections, sexual health, or management of HIV.

In the HOW Project, trained facilitators, all of whom were African American or Latina with group therapy experience, collaborated and facilitated groups with HIV-positive, ethnically similar peer mentors with child sexual abuse histories. Peer-facilitated programs are a core component of the gender-sensitive programming recommended by the OWH Forum, especially "qualified HIV-positive women as peer health educators, primary and secondary prevention promoters, and service advocates for people living with HIV" (Chapter 3, Recommendation E). In the ESHI, peer facilitators are trained in cultural competence through guided discussion of the histories and cultures of the participants' ethnic groups and how those histories potentially factor into women's decision making and behaviors. Cultural competence also includes a discussion of women's rights (which are listed and posted during each session of the intervention), and how cultural values like interconnectedness (Wyatt, 2009) can seem like submission to an overly controlling partner or others who are unfamiliar with religious or cultural values.

What a Violence Prevention Intervention can Achieve

Community-based implementation of the HOW Project yielded several beneficial results. Some of these accomplishments occurred at the individual level, such as sexual risk reduction and increased HIV medication adherence among those who attended eight or more sessions, as described in our main outcomes paper (Wyatt et al., 2004). This is a very important finding, given that we now know that early HIV treatment and adherence is so central to minimizing risks for viral transmission (HIV Prevention Trials Network, 2011; Institute of Medicine, 2010). Additionally, our project improved women's mental health (Table 3), even for those who did not immediately participate in the intervention, and, to a lesser extent, for those who received supportive services but not the intervention itself. Taken together, our results highlight the importance of focusing on violence and trauma histories and PTSD symptom reduction in future mental health-related interventions.

We saw clearly in our project that, unlike interventions that focus on behavior change alone, interventions addressing mental health needs should incorporate follow-up sessions conducted during clinic visits over a longer period of time (e.g., every 3 months for a year), with special attention to using cognitive and trauma-related skills to target core symptoms (e.g., sexual trauma symptoms) and to maintain risk reduction (Chesney, Koblin, et al., 2003; Chesney, Chambers, Taylor, Johnson, & Folkman, 2003). It is unrealistic to expect that mental health symptom reduction can be maintained for 1 or more years without ongoing support, especially among women with histories of severe, prolonged violence. Checkups are needed as women learn new trauma coping and risk reduction skills.

Accomplishments were also realized at the community level, in the settings where the intervention was provided, including churches, hospitals, primary health care clinics, HIV services organizations, and women's health organizations. To meet the needs of our community partners who had no training or existing programs to address women's HIV and/or histories of violence, we offered extensive staff and cultural competence training and supervision. This included a curriculum of culturally meaningful sessions and minimal reimbursement to participants (transportation costs only). Further, honoring the CBO conditions, the intervention was offered to all women by using a wait list control design. This allowed us to investigate the intervention's effectiveness in real-world settings, where treatment cannot be denied to those who seek it, and where service provision may not be immediate owing to limited resources and/or other contextual factors.

This strengthening of the workforce, including peer providers, complements the OWH Forum's recommendation to "improve the quality of HIV care and health outcomes for people living with HIV." Furthermore, the Forum participants recommended building cultural competency among providers, especially those who serve in "underserved and/or high HIV incidence areas," as was the case in our project (Chapter 2, Recommendation G-ii).

How can We Bring Home Gender-Responsive Violence Prevention Interventions?

As research, community, and state partnerships endeavor to offer violence prevention interventions to underserved populations in understaffed agencies, several key recommendations should be considered.

Agencies Assessing HIV-Related Services must be Trained to Screen for, and Address, Violence

When agencies address HIV risk reduction, they need to offer services for the associated problems that women encounter, such as violence. HIV-positive African-American and Latina women often seek services from the same agencies. It is important to require that intervention curricula and training materials be piloted on both ethnic groups in the women's primary language. Furthermore, staff training and programs on how to address and screen for histories of violence should be offered to agencies that serve women and adolescents at risk for or living with HIV/AIDS. To inform strategic plans to help women avoid violence and its effects, violence prevention programs should be continually informed and shaped by the experiences and needs of women who have already been victimized.

Regular and Continued Follow-up are Essential to Maintaining Risk Reduction

Mental health symptoms are regularly monitored in clinical settings. The same kind of monitoring should be part of standard, routine care in agencies offering HIV/AIDS and violence prevention services. Future studies should explore how clinics can best follow up with women in these groups. In clinics where HOW is currently being implemented, women come in every 3 months for treatment of HIV and are asked about their ability to manage their stress, trauma, and psychological well-being. This may be a template for other clinics to address health and mental health concerns at the same time during regular clinic visits.

Like HIV-related symptoms, psychological trauma and other effects of sexual abuse may reemerge over time, and therefore may need to be addressed as minority women continue to live with HIV and work on managing their risks on a daily basis. In

addition, HIV-positive women with histories of substance abuse and violence may be at risk for relapse, and so should be assessed, and possibly treated, on an ongoing basis. This long-term follow-up could play an important role in maintaining the engagement of consumers, per the Forum recommendations (Chapter 1, recommendation E).

Appropriate Violence Prevention Promote Women's Mental, Physical, and Sexual Health

Violence prevention interventions should incorporate the components of "what works" for HIV programming for women and girls (Gay et al., 2010; Table 2). The HOW Project worked in large part because it was both culture and gender specific, and peer facilitated, and the ESHI intervention is specifically designed to address diversity among women.

It should be recognized that treatment can increase women's empowerment and reduce mental health sequelae of violence and HIV infection, including symptoms of depression, anxiety, sexual trauma, and PTSD (Table 3). Empowerment strategies have been used extensively in international efforts to combat gender-based violence (Kim, Pronyk, Barnett, Watts, 2008). We suggest that these strategies be 'brought home' to a greater extent (see Garcia et al., 2010; Wright, Perez, & Johnson, 2010). Qualitative data from the journals maintained by HOW participants suggest that women who participated in the intervention made great strides in their sense of empowerment and felt they had gained the psychological "tools" to cope with the after-effects of trauma or to avoid revictimization. One woman wrote, "The shame seems to be letting me go. With group sessions I'm learning how to change my behaviors and stop repeatedly hurting myself." We also suggest that an important part of prevention is culturally specific interventions for perpetrators of violence, who may also be in need of interventions that address histories of abuse (Welland & Ribner, 2010).

By focusing on sexual health and reducing sexual trauma symptoms, interventions can address women's sexual health needs beyond HIV/AIDS, contraception, gynecological health, and advocacy, to ensure gender-specific health care.

The Right to Health Encompasses the Right to Adequate Mental Health Services, Including Violence Prevention

Women cannot achieve health unless their mental health needs are also addressed. As stated by the World Health Organization, there is "no health without mental health" (Prince et al., 2007). Initiatives such as the HOW Project incorporate an integrated platform of care by addressing risk behaviors and mental health symptoms. Interventions designed to fit the parameters of CBOs and surrounding communities can be utilized in diverse settings, including primary care and mental health clinics.

Group treatment of women's symptoms is both cost effective and particularly therapeutic when it directly utilizes the strengths of a peer support approach. In the HOW Project, women's trauma writings suggested that they benefitted greatly from sharing their experiences with one another. One woman, for example, wrote, "With the help of this group, I was able to find myself and now I can be me. I can be happy. I can feel safe that I have people in my life who actually care about me."

As demonstrated in our project, even under-resourced community-based treatment environments can be strengthened by building capacity for violence prevention services among available staff who have little or no prior training in this area. In our project, facilitators were ethnically matched with the participants, further supporting a nurturing and harmonious environment in which women can interact with health and cultural role models.

Investment is Needed to Make This Provision Possible

Scale up of effective interventions and programming requires that state and national priorities be adjusted to include prevention of gender-based violence. We will continue our efforts to refine our program and enhance its applicability in multiple settings, with plans to scale up, if possible, in the next 5 to 10 years. The staff training we provided has equipped the CBOs with the tools to offer an evidence- and peer-based intervention to ethnic minority HIV-positive women with sexual trauma histories. This also, fortunately, has prepared them to be effective partners in future research trials.

We have taken one step. But the momentum will grow when national, state, and local leaders address gender-based violence as a public health priority and a civil right. When that occurs, the efforts of grassroots organizations to promote violence prevention will be endorsed, funded, and implemented to make a difference for girls and women who are at risk for, or infected with, HIV.

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