Providing Trauma-Informed Care at Health Centers for HIV-Positive Men Who Have Sex with Men

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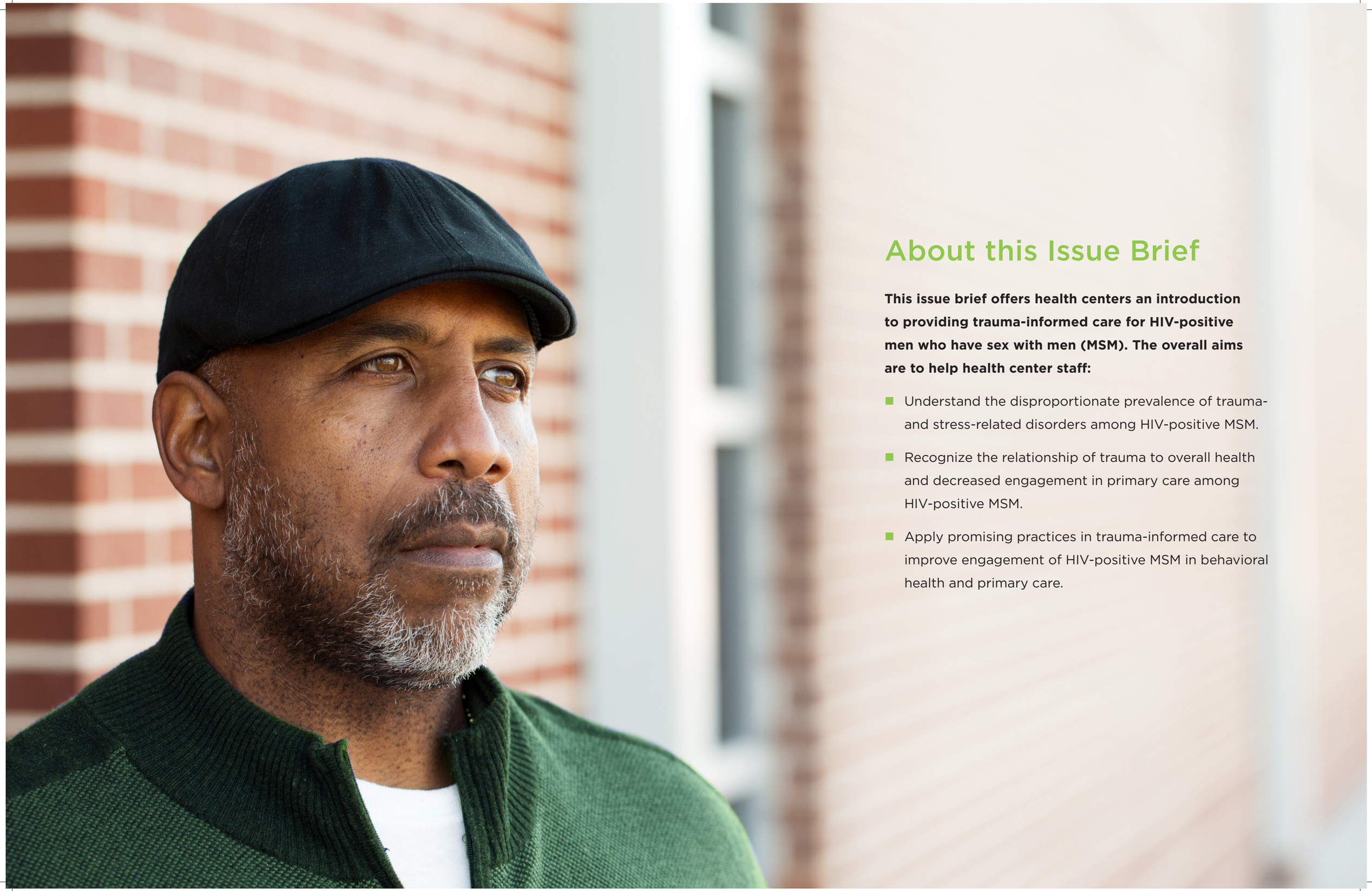


About this Issue Brief

This issue brief offers health centers an introduction to providing trauma-informed care for HIV-positive men who have sex with men (MSM). The overall aims are to help health center staff:

- Understand the disproportionate prevalence of trauma- and stress-related disorders among HIV-positive MSM.
- Recognize the relationship of trauma to overall health and decreased engagement in primary care among HIV-positive MSM.
- Apply promising practices in trauma-informed care to improve engagement of HIV-positive MSM in behavioral health and primary care.

Trauma and Associated Health Issues among HIV-Positive MSM

People living with HIV (PLWH) experience disproportionately high rates of trauma throughout the life course.[1] In a large study of PLWH in the southern U.S., more than 70% reported two or more traumatic events in their lifetime. Over half the participants had a history of sexual and/or physical abuse, and nearly one-third had been physically and/or emotionally neglected in childhood.[2,3] Exposure to trauma can lead to serious mental health issues, including posttraumatic stress disorder (PTSD).[1] The prevalence of PTSD among PLWH ranges from 5% to 74%, as compared to 7% to 10% in the general population.[4]

Men who have sex with men (MSM), particularly within communities of color, are among the U.S. populations with the highest incidence of HIV.5 Among PLWH, the prevalence of trauma history for MSM is comparable to men who have sex with women, but MSM have more posttraumatic stress symptoms, including dissociation (i.e., psychological detachment from reality).[6,7] Trauma in the form of childhood sexual abuse is especially common among HIV-positive MSM. Twenty-five to 65% of HIV-positive MSM report experiencing childhood sexual abuse,[8,9] which is correlated with dissociative symptoms.[6,10]

HIV-positive MSM face chronic stress from stigma relating to their HIV status as well as their sexual orientation. As described by Ilan H. Meyer and Mark L. Hatzenbuehler,[11,12,13] sexual minority stress among MSM stems from discrimination, marginalization, and violence, which can lead to disruptions in coping mechanisms, emotional regulation, interpersonal attachments, and cognitive functioning. This stress can also precipitate everyday expectations of rejection, distress related to identity concealment, and internalized homophobia. Sexual minority stress among HIV-positive MSM can ultimately result in decreased self-care, decreased engagement in primary care, and poor HIV-related outcomes.

Multiple studies have found strong associations between trauma history, PTSD, and HIV sexual transmission behaviors.[6] Among HIV-positive MSM, a history of sexual abuse has been linked to condomless anal intercourse with casual partners.[14] PTSD symptoms have been shown to increase the odds of engaging in sexual risk behavior among young HIV-positive MSM[15] and among HIV-positive Black men who have sex with men and women.[16] Discrimination-based interpersonal trauma, including bias associated with being Black, HIV-infected, or gay, has been linked with condomless anal intercourse.[17]

Traumatic stress adversely impacts the immune system, contributing to physical and mental health issues.[6,18] Among HIV-infected MSM and other PLWH, a history of trauma is not only associated with mental health sequelae and sexual risk behavior, but also with poor cognitive and physical functioning, including HIV disease progression.[2,19,20] Researchers have observed a dose-response relationship between number of lifetime traumatic events and negative health and behavioral outcomes.[3,9] Correlations also exist between trauma history—especially childhood abuse—and poor adherence to antiretroviral therapy (ART).[3,8,21] PTSD symptom severity and psychological dissociation symptoms are associated with lower ART adherence.[22]

Unless more is done to recognize and address trauma among PLWH, the intersecting epidemics of trauma and HIV will continue to create harm at both individual and population-health levels.[6] The adoption of a trauma-informed approach by health centers and other safety net providers, as outlined below, has the potential to bring about dramatic improvements in the health of HIV-infected MSM.[6,23]

Trauma-Informed Care: Promising Practices for Health Centers

According to the Substance Abuse and Mental Health Services Administration (SAMHSA),[24] a trauma-informed service organization:

- Realizes widespread impact of trauma and understands potential paths for recovery.
- Recognizes signs and symptoms of trauma in clients, staff, and others involved with the system.
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices.
- Seeks to actively resist re-traumatization.[24]

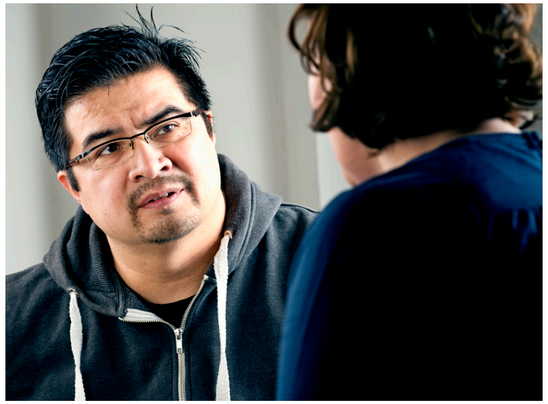
In recent years, several evidence-informed treatments designed to improve posttraumatic stress symptoms have emerged.[6,23,24] Implementation of these strategies to target the effects of trauma on the health of MSM has been inconsistent, including at health centers. When incorporating a trauma-informed approach for HIV-positive MSM, health centers should consider including the following guidelines.[6,24] Most of these suggestions can be adapted to support other vulnerable populations as well.

Create a trauma-sensitive practice environment

- Provide training to ensure a sense of safety in all patient interactions with staff members, including clinical and non-clinical staff.
- Educate staff on how trauma affects engagement in care:
  - A history of interpersonal trauma can contribute to mistrust of caretakers and increased likelihood of being re-traumatized.
  - Prior traumatic experiences can influence patients' reactions in subsequent interactions, such as the process of seeking care.
- Promote retention in care by encouraging engagement through collaboration, transparency, trust, and consistent supportiveness.
- Integrate behavioral health services with primary care in order to consistently engage and retain patients. For resources on behavioral health integration, visit the SAMHSA-HRSA Center for Integrated Health Solutions (www.integration.samhsa.gov).
- Identify and build relationships with local trauma-related services.
- Become familiar with the resources in SAMHSA's online National Center for Trauma Informed Care (www.samhsa.gov/nctic). Founded in 2005, the NCTIC serves to:
  - Promote awareness and implementation of best practices.
  - Disseminate resources and referrals for trauma-focused treatments.
  - Define trauma-informed care as an organizational approach rooted in principles that focus on being mindful of and responding to people who have experienced or may be at risk of trauma, rather than a particular set of rigid procedures.[24]

Implement screening processes

- Screen all HIV-positive MSM for a trauma history. Several validated trauma screening instruments are available.[24]
- Trauma screening should include assessment for intimate partner violence,[6,24] for example with the Intimate Partner Violence Screening Tool.[25]
- If a trauma history is identified, assess specifically for posttraumatic stress symptoms. Evidence-informed screening tools for PTSD include the "Primary Care PTSD Screen" (PC-PTSD) and the "PTSD Checklist".[24]
- In addition, screen for high-risk behaviors associated with trauma among MSM, including unprotected sex and inadequate ART adherence.[6]



Respond to screening results

- For HIV-positive MSM with negative trauma screening results, health centers can educate patients about increased risk of traumatization and how to seek help if needed.
- For HIV-positive MSM who screen positive for trauma, teach them about the connection between trauma and its negative impact on behavioral and physical health.[6,24]
- Provide prompt resources and referrals for specialized trauma-specific treatments (if local services exist), such as cognitive processing therapy for PTSD.[26,27]
- Health centers in resource-limited areas can access the previously mentioned SAMHSA's online National Center for Trauma Informed Care (www.samhsa.gov/nctic), which offers hotlines, referral options, tools for treatment, and support services.
- Tailor interventions for HIV-positive MSM, with a customized approach to symptom reduction, including strategies to prevent trauma relapse. This approach can significantly enhance ART adherence and mitigate high-risk behaviors.
- Integrate trauma-focused treatment services, or other psychosocial interventions that target posttraumatic stress symptoms, into primary care, including antiretroviral medication management to improve adherence.[21,22] There are effective behavioral interventions for increasing antiretroviral adherence among MSM, such as Life-Steps.[28,29]
- Combine biomedical with behavioral treatment strategies. Behavioral health treatments that restructure distressing cognitions can improve self-care and physical health outcomes among HIV-positive MSM.
- Focus on promoting resilience among HIV-positive MSM by helping to build skills for overcoming adversity through strengths-oriented questions.[24]
- Finally, identify and involve family and other social supports to help with treatment:
  - Friends and family can help detect problems early; they also often function as advocates for HIV-positive MSM seeking services.[6]
  - Patients in serodiscordant relationships may benefit more from treatment strategies that include their partner, rather than just individual treatment.[6,30]

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