Providing Sensitive Care for Adult HIV-Infected Women With a History of Childhood Sexual Abuse

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Childhood sexual abuse (CSA) is a serious public health issue. Women with HIV who have a history of CSA are at increased risk for sporadic medical treatment, nonadherence to HIV medications, and HIV risk behaviors. These associations pose a challenge to providing health care for this population and are complicated by the possible psychological sequelae of CSA, such as anxiety, depression, dissociation, and posttraumatic stress disorder. This article reviews the effects of CSA on the health status of women with HIV, barriers to treatment adherence, suggested components of trauma-sensitive medical care, and mental health approaches. A trauma-informed, trauma-sensitive care model that addresses barriers associated with health care for women with a history of CSA is suggested. Specific recommendations are offered for the provision of effective clinical care for women with HIV who also have a history of CSA to help HIV care providers better recognize and appreciate the distinct needs of this patient population.

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Childhood sexual abuse (CSA) is a serious public health problem. Estimated rates of CSA in women in the United States have ranged from 20% to 25% (Dube et al., 2005; Felitti et al., 1998). One in five women is raped in her lifetime, and of these, approximately half experience rape before the age of 18 years (Centers for Disease Control and Prevention [CDC], 2012). More than one third of women who were raped as minors are also raped as adults. Women with HIV have particularly high rates of abuse and trauma, with reported rates as high as 2-fold that of the general population (Briere & Elliott, 2003; Fergusson, Boden, & Horwood, 2008). CSA in women has potential lifelong psychological effects that are associated with a high risk of HIV acquisition and poor adherence to medical care following a diagnosis of HIV (Maniglio, 2009).

A continuum of risk exists for women who experience CSA, with early abuse leading to later abuse and violence, which in turn may increase the risk of behaviors that lead to HIV infection (Fergusson et al., 2008). The associations between CSA and later engagement in sexual risk behaviors have been well documented, with CSA linked to sex work, sexual risk behavior, multiple sex partners, and substance abuse (Greenberg, 2001; Wingood & DiClemente, 1997; Wyatt et al., 2002; Zierler et al., 1991). Women who have experienced

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CSA have a 2-fold elevation in risk for lifetime domestic violence and a 4.25-fold increased risk of illicit drug use compared with women without such a history (Fergusson et al., 2008). CSA survivors have reported a lifetime history of greater exposure to various traumas as well as greater levels of mental health symptoms (Banyard, Williams, & Siegel, 2001a).

The intention of this review article is to help sensitize HIV providers to the distinct needs with which women with a history of CSA may present. It is recommended that HIV care programs for women address the effects of CSA. Delivery of health care that acknowledges and addresses the psychosocial sequelae of sexual abuse and violence may help increase treatment and medication adherence rates for women with HIV. This article reviews the effects of CSA on the health status of women with HIV, barriers to treatment adherence, suggested components of trauma-sensitive medical care, and mental health approaches that may enhance HIV care and promote adherence.

Defining CSA

The search terms that were utilized for this review included *childhood sexual abuse, child sexual abuse,* and *childhood sexual trauma.* The National Society for the Prevention of Cruelty to Children (n.d.) defined CSA as "persuading or forcing a child to take part in sexual activities, or encouraging a child to behave in sexually inappropriate ways" (para. 1). The legal definitions of CSA by state may encompass different types of sexual activity, including voyeurism; sexual dialogue; fondling; touching of the genitals; vaginal, anal, or oral rape; and forcing a child to participate in pornography or prostitution (Childhood Welfare Information Gateway, n.d.).

Prevalence rates of CSA vary among studies according to the definitions used. Because of the varying social, legal, and moral definitions of CSA, there is little consensus as to the cutoff age or types of sexual activities that are considered abuse for the purposes of research. Most studies use a cutoff point of 16 to 18 years, but because the majority of occurrences of abuse take place during the prepubertal years of 8 to 12 years, the later cutoff points do not affect the prevalence data (Coleman & Coleman, 2002). In one meta-analysis of CSA, the majority of studies (70%) defined CSA as occurring if a sizable age discrepancy exists between the child or adolescent and the other person regardless of the younger person's willingness to participate (Rind, Tromovitch, & Bauserman, 1998). Twenty percent of the studies in that meta-analysis limited the definition of CSA to only unwanted sexual experiences. Three fourths defined CSA as including both contact and noncontact (e.g., exhibitionism) sexual experiences, whereas one fourth restricted the definition to contact experiences only (Rind et al., 1998).

Effects of CSA on Health Status

CSA is more prevalent among women living with HIV than women in the general population and, thus, it is important to examine the relationship between CSA and HIV as it relates to women's health care and health outcomes (Koenig, Doll, O'Leary, & Pequegnat, 2004). CSA is associated with a number of physical, psychological, and behavioral consequences for the survivor (Maniglio, 2009). Symptoms resulting from CSA likely persist long after the abuse has ended, and, therefore, it is important to consider the long-term nature of these effects in defining the impact of CSA on women's overall health status.

CSA and HIV

There appears to be a relationship between CSA and HIV risk behavior (Arriola, Louden, Doldren, & Fortenberry, 2005), with HIV infection in adulthood being a possible health-related consequence for survivors of CSA (Zierler et al., 1991). There is an association between CSA and subsequent sexual risk behaviors in women, with a reported 7-fold increase in HIV risk behaviors associated with early and chronic sexual abuse (Bensley, Van Eenwyk, & Simmons, 2000; Senn, Carey, & Vanable, 2008). Specifically, CSA has been related to later engagement in unprotected sexual intercourse, sex with multiple partners, and sex trading (i.e., sex for money, drugs, shelter; Arriola et al., 2005). However, it is important to note that it remains unknown how many women are infected with HIV by a sexual abuser during childhood. CSA survivors are at high risk for revictimization. One study found that 67%

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