Research Brief

The Implications of Intimate Partner Violence on Health-Related Quality of Life Among Adults Living With HIV Who Experienced Childhood Sexual Abuse

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Health-related quality of life (HRQoL) refers to the perception of personal health across multiple domains (e.g., physical, emotional, social well-being), and is an important indicator of disease progression for people living with HIV (PLWH; Persons, Kershaw, Sikkema, & Hansen, 2010). HRQoL is influenced by sociodemographic factors such as race and sexual identity as well as clinical factors such as physical symptoms (Vyavaharkar, Moneyham, Murdaugh, & Tavakoli, 2012). For example, among PLWH, those with more HIV-related symptoms and comorbid health problems experienced poorer HRQoL (Persons et al., 2010).

While existing research has underscored the impact of sociodemographic and clinical factors on HRQoL among PLWH, experiences of interpersonal violence such as intimate partner violence (IPV) and childhood sexual abuse (CSA) may also play an important role. In the United States, IPV is defined as the physical, sexual, and psychological harm inflicted by an intimate partner (Black et al., 2011). The prevalence of IPV in the general U.S. population is 28.5% and 35.6% for men and women, respectively (Black et al., 2011), but the IPV prevalence for PLWH has been estimated as almost double general population estimates (Pantalone, Hessler, & Simoni, 2010). To date, the few studies that have examined the impact of IPV on PLWH show that IPV experiences are associated with reduced HRQoL (Pantalone et al., 2010).

One critically important subpopulation, adult PLWH who experienced CSA, has been particularly overlooked in quality-of-life research. Adults who experienced CSA have often reported poorer HRQoL compared to those without such experiences (Chartier, Walker, & Naimark, 2007). Yet, we are aware of only one study that has examined risk factors of reduced HRQoL among adult PLWH who experienced CSA (Persons et al., 2010), and IPV was not included as a predictor. This dearth of studies is concerning as the prevalence of CSA in adult PLWH has been shown to range between 30% and

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53% (Markowitz et al., 2011), and CSA is strongly associated with an increased risk of IPV in adulthood (Classen, Palesh, & Aggarwal, 2005; Daigneault, Hébert, & McDuff, 2009). Given this increased vulnerability, studies examining IPV as a risk factor for reduced HRQoL among adult PLWH who experienced CSA are needed for the development of IPV-informed HIV care and retention programs.

We aimed to describe the prevalence of IPV among adult PLWH who experienced CSA and examine the unique contributions of IPV on overall HRQoL and each dimension of HRQoL (i.e., physical well-being, emotional well-being, social well-being, function and global well-being, and cognitive functioning) above and beyond the effects of known correlates.

Methods

Our study is a secondary data analysis of data collected from a pilot trial of an individual psychotherapy intervention for adult PLWH who experienced CSA (Hansen, Brown, Tsatkin, Zelgowski, & Nightingale, 2012). Participants were recruited from HIV specialty clinics in an urban area in the northeast region of the United States. Flyers were posted in order to recruit participants for the study in addition to provider referrals. Potential participants were screened for eligibility via phone. The eligibility criteria were: (a) at least 18 years of age, (b) English-speaking, (c) living with HIV infection, and (d) reported childhood sexual abuse (i.e., sexual exposure, sexual touch, or anal, oral, or vaginal sex). CSA was operationalized as nonconsensual sex or consensual sex by someone at least 5 years older than the participant if the participant was age 12 years or less, or 10 years or older if the participant was between ages 13 and 17 years (Hansen et al., 2012).

Eligible participants were invited to participate in a formal screening assessment at a local community organization and were asked to sign an informed consent form to participate in a two-part screening interview consisting of questions on trauma history, sociodemographics, and the Structured Clinical Interview for the *Diagnostic and Statistical Manual*, 4th edition (First, Spitzer, Gibbon, & Williams, 2002). The interviews were administered in English by doctoral-level psychologists or fourth-year clinical psychology practicum students using a computer-assisted personal interview in a private space. Participants were screened between March 2009 and November 2010. Eligible participants completed a second consent form to participate in the intervention study and the baseline interview. Participants were remunerated $40 for each screening interview and $50 for the baseline interview. Our study used complete data from screening and baseline interviews, resulting in a final sample of 78 participants. Study procedures were approved by Yale University's institutional review board.

IPV was assessed using 20 questions administered as a structured interview on physical (e.g., slap, hit, punch, shove, or used other physical force against you) and sexual (e.g., used threats or force to make you have sex) violence experienced with past and current partners. A dichotomous summary variable was created: physical or sexual IPV (yes to any physical or sexual IPV acts in a past or current relationship). HIV symptom severity was assessed using a 20-item HIV Symptom Checklist (Folkman, Chesney, Collette, Boccellari, & Cooke, 1996). Participants rated each symptom as either *Present* (1) or *Not present* (0). Symptoms were summed to create a total score, with higher scores indicating more symptoms (Cronbach's alpha of 0.84). Comorbidities were assessed using a 25-item Comorbidity Index (Selim et al., 2004). Participants stated whether each condition was *Present* (1) or *Not present* (0). Examples of conditions were depression and cancer. Conditions were summed to create a total score, with higher scores indicating more conditions (Cronbach's alpha of 0.70). HRQoL was assessed using the revised 44-item Functional Assessment of Human Immunodeficiency Virus Infection (Peterman, Cella, Mo, & McCain, 1997). The Functional Assessment of Human Immunodeficiency Virus Infection assessed overall quality of life and five subscales: emotional well-being, social well-being, cognitive functioning, physical well-being, and function and global well-being. Participants rated their well-being on a 4-point scale from *Not at all* (0) to *Very much* (4). Responses were summed to obtain a total score for overall quality of life and each subscale, with higher scores indicating higher well-being (Cronbach's alphas were: 0.93 [overall], 0.89 [physical well-being], 0.85 [emotional well-being], 0.65 [cognitive functioning], 0.86 [function and global well-being], and 0.86 [social well-being]).