



Characteristics of IPV

Health Consequences

Provider Strategies

Who Is at Risk?

## INTIMATE PARTNER VIOLENCE

*Providers recognize that patients may have past trauma, but what few realize is how prevalent it is and how much it affects patients' health. Our findings<sup>1</sup> showed that 1 out of every 2 HIV-positive patients who walk through the door—regardless of gender—have a history of [intimate partner] violence and/or childhood sexual abuse.*

—Michael Mugavero, researcher  
*Coping With HIV/AIDS in the Southeast*

Intimate partner violence (IPV), also called domestic violence, is behavior that results in emotional, physical, sexual, or psychological harm to a current or former partner or spouse.<sup>2,3</sup> IPV occurs in all communities and in all types of relationships,<sup>4</sup> and it has extensive physical, mental health, social, and economic consequences.<sup>2,5</sup>

Verbal abuse is the single variable most likely to predict IPV.<sup>6</sup> IPV is neither a spontaneous act of anger nor a one-time occurrence.<sup>6-8</sup> Instead, IPV is about gaining control. A 2004 study noted that “often, perpetrators tailor abuse to the specific vulnerabilities of the partner and will use whatever means of coercion or control are available to them to dominate.... Batters are ingenious in choosing their weapons of control.”<sup>9</sup>

## DID YOU KNOW?

In the United States, approximately 1.5 million women and 835,000 men are raped or assaulted by a partner each year.<sup>10</sup>

Less than 10 percent of HIV providers routinely screen for IPV,<sup>11</sup> yet incidence is highly disproportionate among populations at risk for HIV.

People convicted of domestic violence misdemeanors are federally banned from gun ownership.<sup>12</sup>

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U.S. Department of Health and Human Services  
Health Resources and Services Administration

Many schools of nursing, medicine, and public health do not offer training on intimate partner violence (IPV). Outside of emergency rooms, IPV screenings and protocols can be scarce. In many clinics, screenings are offered only to women in particular age groups, thereby missing opportunities to identify IPV among many other at-risk populations. And in an environment where we are asked to do more with less, the task of screening—and treating—IPV can seem overwhelming, if not downright impossible.

But who will treat IPV among HIV-positive persons if we don't? Who is better able to interact with and detect violence among these patients than we are? Addressing IPV is a public health issue because the psychological, physical, and emotional harm IPV causes can be dramatic. The earlier we detect IPV, the sooner we can get patients into therapy and improve their health outcomes. By the time patients appear with scratches and bruises, abuse has likely been longstanding. If we are diligent, however, we can identify the early warning signs and help patients build healthier relationships and lead healthier lives.

Deborah Parham Hopson  
HRSA Associate Administrator for HIV/AIDS

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### **HRSA CARE Action**

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Cover and page 6, See Change library; page 4, transgender client in Ohio; page 9, client and care provider, MS.  
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### **THE CYCLICAL NATURE of IPV**

Violence often occurs in cycles; the phases have been characterized as *tension building*, *acute battering*, and *honeymoon*.<sup>8</sup> And although depression, homelessness, past history of abuse, poverty, stress, substance use, and unemployment can be linked to IPV, many people who experience such situations never become batterers or experience battering. Similarly, amelioration of such problems may not reduce IPV.<sup>8,13</sup> Distinct connections between IPV and several of these issues—including HIV transmission—cannot be overlooked.

For example, past history of childhood sexual abuse (CSA) increases the likelihood of sexual victimization as an adult.<sup>6,9,14</sup> Survivors of IPV often turn to alcohol and drugs to cope with abuse; substance abuse, in turn, can decrease inhibitions and increase HIV risk. The use of cocaine or methamphetamine, in particular, can increase the likelihood of engaging in high-risk sexual behaviors, which bring increased vulnerability to violence and HIV.<sup>2,13,15</sup> IPV trauma has also been shown to decrease immune functioning,<sup>8,13</sup> negatively affect medication adherence and, for many survivors, lead to depression and posttraumatic stress disorder (PTSD).<sup>4,14</sup> The term *syndemic* has been used to describe the inextricable and mutually reinforcing connections among violence, substance abuse, and HIV/AIDS.<sup>16-18</sup>

"Addressing IPV is further complicated because of social stigma. No one wants to talk about it," explains Jessica Xavier, a public health analyst at the Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau. Yet, understanding IPV and the myriad health issues that accompany it has important implications for effective HIV prevention and risk reduction as well as for health outcomes.

### **SURVEILLANCE DATA**

The populations most at risk for HIV are also those most at risk for violent trauma, both physical and sexual. Racial and ethnic minorities experience higher rates of IPV than do Whites.<sup>6</sup> Rates of IPV in urban and rural settings are comparable, however.<sup>8</sup> Men who have sex with men (MSM) may be more susceptible to IPV than are heterosexual

men.<sup>9</sup> When comparing women and men, regardless of sexual orientation, women report significantly higher rates of abuse. Rates of IPV among lesbian, gay, bisexual, and transgender (LGBT) persons are thought to be similar to those among heterosexual women, but because of underreporting and reporting biases on the part of survivors, perpetrators, and people charged with addressing IPV (e.g., police), the data are unclear.<sup>4</sup>

### MISCONCEPTIONS ABOUT WHO IS AT RISK

Preconceived notions about IPV mean that clinicians may not recognize patients who are at risk. For example, many people—clinicians included—overlook male survivors of IPV as well as female batterers.<sup>19</sup> The assumption that “bigger” partners must be abusers and “smaller” partners must be survivors can also deter people from

coming forward about IPV. Perpetrators of IPV often have a history of victimization. In fact, “previous partner aggression remains one of the strongest predictors for future aggression by both males and females.”<sup>20</sup> As a result, HIV providers may see not only survivors of IPV but also perpetrators who were once survivors of abuse themselves. In some relationships, the issue of mutual aggression may be present.

IPV survivors may also be overlooked because of age or disability. Older women are rarely screened for IPV. In addition, providers may not fully understand the unique needs of older survivors or may associate signs of IPV with old age.<sup>11</sup> About younger women, “another misconception... is that pregnancy will diminish IPV. That is not always the case. In fact, in some relationships an unplanned pregnancy can further spike violence,” ex-

## ➔ INTIMATE PARTNER VIOLENCE—THE HARSH REALITY

<p><b>Women</b></p>	<ul style="list-style-type: none"> <li>▶ Close to 5.3 million women ages 18 and older experience IPV annually.<sup>5</sup></li> <li>▶ In 2004, nearly 33 percent of female homicide victims were killed by intimate partners.<sup>20</sup></li> <li>▶ IPV among women with HIV or at risk for HIV may be as high as 67 percent—a rate 3 to 4 times greater than among HIV-negative women.<sup>21,22</sup></li> </ul>
<p><b>Youth</b></p>	<ul style="list-style-type: none"> <li>▶ Approximately 25 percent of adolescents report verbal, physical, emotional, or sexual abuse from a dating partner each year.<sup>23</sup></li> <li>▶ Dating violence among adolescents is highest among African-American girls.<sup>20</sup></li> <li>▶ 1 in 5 high school girls have been physically or sexually abused by a dating partner.<sup>24</sup></li> <li>▶ More than one-half of female rapes occur before age 18, and 22 percent of those rapes occur before age 12.<sup>10</sup></li> </ul>
<p><b>MSM and Transgender Persons</b></p>	<ul style="list-style-type: none"> <li>▶ In a multicity study, nearly 72 percent of people who are transgender reported violence in the home.<sup>25</sup></li> <li>▶ A multicity study on urban MSM found that 1 in 5 men had been physically battered by a partner and that 1 in 20 had been sexually battered during the previous 5 years.<sup>9</sup></li> <li>▶ A California study found that LGBT persons who are incarcerated are sexually assaulted at a rate 15 times higher than that of the general inmate population.<sup>26</sup></li> </ul>



➔ *Almost every State has domestic violence shelters, but few have shelters that are gay or transgender friendly.*

plains Sabrina Matoff-Stepp, director of HRSA's Office of Women's Health (OWH). In April 2008, the OWH sponsored a Webcast addressing the intersection of violence and HIV/AIDS among women. (Visit <http://webcast.hrsa.gov/Postevents/archivedWebcastDetailNewInterface.asp?aeid=448> to access the Webcast.)

"There are a number of misconceptions about who can be survivors of violence," says Michael Relf, assistant dean for undergraduate programs at the Duke University School of Nursing. "What's commonly perceived is that two men should be able to defend themselves, so if violence happens, isn't it mutual combat? In same-sex relationships, there's the idea that there must be equal power, or if there's a survivor and a perpetrator, that violence somehow wasn't deliberate."

### ISSUES AROUND REPORTING

IPV is believed to be underreported because of issues such as shame, stigma, and fear that reporting will escalate violence.<sup>8</sup> "You have to keep in mind that for same-sex IPV, it's a stigma within a stigma," says Xavier.

Relf adds, "In many States, domestic violence is defined as male-perpetrated violence against women. If there's a disruptive occurrence in the home between two men, everyone gets arrested. In addition, many States don't have a system in place to deal with violence involving transgender people. As a result, the vulnerable get further victimized." MSM and transgender persons may find that IPV resources are not available to them and thus see no point in reporting the abuse.<sup>19</sup>

Consequently, most IPV events are not reported, particularly those involving men and transgender persons.<sup>6</sup> Reasons that survivors give for not reporting may include fear of institutional discrimination (i.e., secondary victimization) as well as the stereotype of IPV survivors as women in heterosexual relationships.<sup>27</sup> "Many police jurisdictions, firefighters, and paramedics have not had appropriate training regarding IPV, particularly as it applies to MSM and transgender persons," says Relf. "And while almost every State has domestic violence shelters, rarely do they have shelters that are gay or transgender friendly. In some cities, domestic violence shelters may have vouchers to stay in a hotel or they may allow transgender women to stay. When I was working in Washington, DC, the only safe place to refer our MSM patients was a homeless shelter," Relf adds. Transgender persons may face additional challenges accessing social services if their identification and current name do not match.<sup>27</sup>

Some States require survivors to have a legally recognized relationship with their offender in order to file civil protection orders. (The Lambda Legal Defense and Education Fund [[www.lambdalegal.org/](http://www.lambdalegal.org/)] and the National Center for Lesbian Rights [[www.nclrights.org](http://www.nclrights.org/)] provide information about specific State laws.)

Survivors, particularly MSM and transgender persons, often do not disclose violence to family and friends. Lack of support can create added stress. As IPV escalates, survivors experience "shock, denial, withdrawal, confusion, psychological numbing, and fear [as well as] a loss of self-esteem, self-respect, identity, control, initiative, decisiveness, resources, and power."<sup>8</sup>

"This type of violence destroys possibilities of safer sex across populations," says Xavier. For many people, honest disclosure, safer sex negotiation, and equal interpersonal power are the exception rather than the norm, and attempting to change the structure of or practices within the relationship is often unrealistic. In fact, discussing safer sex within a violent relationship often escalates abuse.<sup>8,21,28</sup>

## WHY SURVIVORS STAY

Although no single reason can explain why survivors of IPV stay with batterers, several common themes are reported across populations.

People in violent relationships often stay because they love the abusive partner and hope he or she will change. Other motivations may include social isolation, language barriers, fear of deportation, concern that children will be taken from the home, and even blackmail over disclosing HIV status or sexual orientation to family and friends.<sup>8</sup> Compounding those challenges is the fear that leaving will not make the survivor any safer—termination of a relationship can sometimes spark violence.<sup>6,8</sup>

Drug use can complicate motivation to leave an abusive partner if he or she is a drug-providing or drug-sharing partner.<sup>15</sup> And for HIV-positive patients, fear of becoming sick and dying alone can contribute to staying in an abusive relationship. Conversely, survivors may stay in a relationship with someone who is sick out of guilt over leaving him or her. This situation may be particularly true for women who assume caretaking roles, given traditional social and gender norms.

Abusers may control finances and medical care coverage, inhibiting a survivor's ability or willingness to leave.<sup>21</sup> In fact, it appears that "the most likely predictor of whether a survivor will permanently separate is whether or not he or she has enough financial resources to live without the survivor's support."<sup>8</sup>

## HEALTH CONSEQUENCES

*For IPV survivors, so much time and energy goes into daily living that sometimes they miss HIV-related signs and symptoms or other health problems. HIV is a lower priority in a long list of other struggles.*

—Sabrina Matoff-Stepp

Verbal and physical abuse have deleterious effects on self-esteem and can affect health outcomes as a result

of injury, decreased willingness to access health services, decreased adherence, and psychological distress, all of which negatively affect immune function. This kind of physical stress has been shown to promote HIV progression.<sup>8</sup>

IPV can increase the risk of eating disorders, alcohol and substance abuse, suicide, and HIV reinfection. It also can lead to physical ailments, including internal bleeding, broken bones, head trauma, severe lasting disabilities,<sup>7</sup> chronic gynecological and central nervous system problems, and even death.<sup>20,29</sup> Outcomes of IPV are wide ranging and can encompass complications in pregnancy and childbirth, including miscarriage; chronic somatic disorder (a psychological disorder in which patients are chronically ill with unknown etiology); exacerbation of chronic medical conditions; depression; anxiety disorders such as PTSD; and social isolation.<sup>4</sup>

Nadia Damm, clinical psychologist at the AIDS Resource Center of Wisconsin, a Ryan White HIV/AIDS Program Parts B, C, and D grantee, observes:

*Patients don't always present with scars and bruising, but they are showing signs of IPV. That is why we do IPV screenings when conducting neuropsychological testing, as head trauma may be due to partner violence.*

Abusers may restrict and monitor all aspects of a survivor's life, including finances, transportation, phone use, and activities outside the house, all of which can impede medical adherence and access to medical appointments.<sup>8</sup> Abusive partners may prevent survivors from receiving regular health care and medical attention to injuries, or survivors may not seek care because they have become unable to recognize bodily signals of distress.<sup>8</sup> Survivors may also forgo medical care or counseling if the abuser has the same provider.<sup>8</sup> Abusive men are more likely to have sexual partners other than their wives, behavior that can increase HIV risk.<sup>8,28,30</sup>

➔ **Abusive partners may prevent survivors from receiving regular health care and medical attention to injuries, or survivors may not seek care because they have become unable to recognize bodily signals of distress.**

Childhood and adolescence are critical times in personal, social, and sexual development.<sup>31</sup> Childhood sexual abuse (CSA) can interrupt and distort survivors' sense of self and their sexuality.<sup>9</sup>

Because CSA survivors were not involved in early decision making about their sexuality, they may be more hesitant to communicate about sex or safer sex practices, even as adults. Survivors of childhood abuse may also reenact behaviors learned in early development or have "scripts" for sexual behavior.<sup>32</sup> In addition, CSA survivors disassociate personal feelings from sex as a safety mechanism, have difficulty trusting others, and often avoid developing attachments to sexual partners.<sup>31</sup>

Early sexual abuse increases the likelihood of engaging in HIV risk behaviors, including sexual relationships with high-risk partners, substance abuse, and reduced ability to assess individual risk and safety.<sup>21,33</sup> Adults with CSA histories may use alcohol and drugs to avoid negative thoughts, emotions, and memories associated with abuse.<sup>31</sup>

CSA can have long-lasting effects on psychological, physical, and social functioning and create increased risk for mood disorders, such as chronic depression and posttraumatic stress disorder, as well as self-destructive behaviors.<sup>28</sup> CSA is also associated with poor treatment adherence and increased risk behaviors for HIV as well as sexual revictimization in adulthood.

The rate of CSA is much higher among people who are HIV positive than among the general public.<sup>34</sup> CSA is also higher among MSM than among heterosexual men.<sup>33</sup>

### **POSTTRAUMATIC STRESS DISORDER**

IPV, trauma, repeated victimization, and living in high-risk environments—all of which are more common among people living with HIV/AIDS (PLWHA)—can lead to PTSD.<sup>22</sup> PTSD is an anxiety disorder that is triggered by a traumatic life event,<sup>35</sup> and depression is also triggered or exacerbated by stress. It is no coincidence, then, that both PTSD and depression are highly prevalent among IPV survivors.<sup>36,37</sup>

Despite its prevalence, PTSD among PLWHA is widely untreated.<sup>36, 38</sup> Studies of PTSD among PLWHA have found prevalence ranging from 30 to 50 percent; approximately 60 percent of those meeting diagnostic criteria for PTSD in the study were not being treated for the condition.<sup>36</sup> This pattern may be, in part, because patients with PTSD can present with any of a number of symptoms, and substance abuse—a comorbidity of HIV, IPV, and PTSD—can mask symptoms.<sup>22</sup>

Indicators for PTSD include (1) exposure to an extreme traumatic stressor involving direct, threatened, or witnessed violence and (2) response to trauma involving fear, helplessness, or horror.<sup>39,40</sup> Symptoms must persist for more than 1 month.<sup>41</sup> Diagnostic symptoms of PTSD include nightmares or flashbacks, avoiding reminders of the traumatic event, dissociation, detachment, emotional numbing, anger, lack of concentration, significant impairments in social and occupational environments, physiological reactivity such as high heart rate, and hyperarousal (indicated by irritability and sleeplessness).<sup>35,36,39,40,42</sup>

Symptoms of PTSD may also include depression; panic disorder; anxiety disorders or attacks; physical complaints such as headaches, respiratory problems, stomach pains, and fatigue; and self-destructive behaviors through alcohol and drug use as well as suicidality.<sup>43</sup> People who suffer from PTSD may

also suffer from feelings of mistrust and alienation, even from close family members and friends.<sup>21,41</sup> PTSD can contribute to a sense of a foreshortened future and a lack of self-protective mechanisms.<sup>38</sup> Cumulative stress, including PTSD, can disrupt biological functioning in the autonomic nervous system; the hypothalamic–pituitary–adrenal axis; and the cardiovascular, metabolic, and immune systems.

Cumulative stress may also elevate cortisol levels that may increase HIV viral replication.<sup>28</sup> PTSD is also associated with poorer adherence to highly active anti-retroviral therapy.<sup>22,42</sup>

### PROVIDER STRATEGIES

Successful IPV interventions share the following components:

- ▶ A written protocol and screening policies
- ▶ Documentation (in progress notes or in charts using body maps or even photographs of injuries),<sup>44</sup> reporting, and referral tools
- ▶ Staff training and community education, i.e., written curricula, manuals, and continuing education
- ▶ In-house IPV coordinators or advocates
- ▶ Availability of prevention information
- ▶ Coordination among IPV, mental health, and substance abuse providers
- ▶ Availability of support groups and services
- ▶ Signed release of information for follow-up
- ▶ Linkages to community resources.<sup>4,44</sup>

How providers implement interventions varies from site to site. No matter how providers execute their interventions, however, the goal is always the same: To keep patients safe and healthy.

#### IPV Screening

Assessing history of IPV and childhood sexual abuse and the presence of PTSD offers an opportunity to implement interventions early and improve health outcomes before advanced disease progression. One way in which health care workers can discuss violence with their patients is to ask empathetic, nonjudgmental questions (e.g., “Because violence is so common these days, I ask everyone if they have been hurt by someone close to them.”)<sup>13</sup>

“In our initial evaluation of clients we use the word ‘hurt,’ because at the onset of therapy, patients may not call what’s going on ‘abuse’ [and] seem to be more comfortable opening up if we don’t brand it that way,” Damm says. This approach helps normalize IPV screenings<sup>45</sup> and can increase patients’ willingness to discuss personal or medical information because they feel they are in a safe and accepting environment. IPV discussion should always take place in private; if an interpreter is necessary, language services should be provided by someone unknown to the patient.<sup>4</sup>

“[Screening] is part of the medical visit for both general medical services and HIV services,” says Sally Neville, director of HIV primary care at the Kansas City Free Clinic in Missouri, a Ryan White HIV/AIDS Program Parts A, B, C and D grantee. “We screen for many things during each visit, then there’s the actual business of the medical visit. Sometimes our providers find there’s simply not the time to ask all the screening questions and accomplish the medical care needed during the visit.”

Barriers to IPV screening include lack of training, time constraints, limited resources for referral (particularly in rural settings), and fear of offending the patient. Yet, identifying IPV is vital to facilitate appropriate referral and effective medical treatment. Screenings for depression and substance abuse will not identify all patients with histories of trauma, despite their high comorbidity with IPV and PTSD.<sup>46</sup> Screenings specific to IPV, therefore, will yield more accurate results.

Reflecting resource constraints, Neville explains an alternative approach:

*Because of our concerns, we’re considering shifting to a social marketing approach—putting posters about IPV on the walls [and] informational pamphlets in the office and in the bathrooms and asking patients to fill out a questionnaire about IPV. If patients answer yes to particular questions, they’ll be referred to a case manager or social worker. This will decrease the requirement for trainings on IPV and free up staff. Social marketing materials will be translated in English and Spanish.*

The clinical value of screening for IPV has been widely accepted by the American Medical Association and other leadership organizations. The American Association of Colleges of Nursing has even published guidelines.<sup>45</sup> Screening, however, cannot be subjective: A

standard protocol must be established, and IPV screening questions should be gender neutral.<sup>2</sup> (For guidelines, see [www.accesscontinuingeducation.com/ACE4000/c7/index.htm](http://www.accesscontinuingeducation.com/ACE4000/c7/index.htm).)

IPV screening also should occur at HIV testing sites. HIV counseling and testing locations offer a confidential and safe setting in which to discuss IPV. By including questions on IPV on the forms that patients fill out before HIV testing, the informed consent process could be used to initiate discussion on the topic.<sup>4</sup>

Amelia Cobb, director of the Partnership to Reduce Intimate Partner Violence and HIV, offers this approach:

*Testing sites need to come up with protocol for IPV screenings and referrals. IPV should be discussed at HIV posttest counseling. Policies need to be developed that are realistic and reflective of the culture. It's easier to screen for IPV at HIV testing sites than test for HIV at a domestic violence shelter.*

Using public health partner notification staff as a resource can also help alleviate the time constraints facing counselors and physicians.<sup>2</sup>

IPV can occur in conjunction with HIV partner notification, however.<sup>2</sup> Partner notification can initiate an abusive reaction, although in most cases abuse relating to disclosure takes place in an existing violent relationship.<sup>4,28</sup> Partner notification is deferred if risk of IPV might further endanger the PLWHA.<sup>2</sup>

When screening minors for HIV and IPV, potential violence from family members, as well as risk of homelessness and suicide, needs to be taken into consideration.<sup>4</sup> Screening tools for youth that may be helpful include the Children's Depression Inventory; the Problem Oriented Screening Instrument for Teenagers; and, in Massachusetts, the Massachusetts Youth Screening Instrument 2.<sup>47</sup>

If universal screening is not feasible, providers should at the very least screen patients who present with

- ▶ physical injury;
- ▶ chronic, nonspecific symptoms such as pain, sleep disorders, or gynecologic pain that has no apparent cause;
- ▶ emergency room treatment or mental health services;
- ▶ late entry into prenatal care or, generally, any delay in seeking treatment for health-related symptoms;

- ▶ history of suicidal thoughts or actions;
- ▶ homelessness (which may be related to interpersonal violence); or
- ▶ irritable bowel syndrome or genital and urinary tract infections.<sup>13</sup>

Other signs and symptoms may include survivors' refusal of IPV screenings,<sup>4</sup> reluctance to disclose status to a partner, reluctance to discuss home life, frequent reference to a partner's anger, hesitation to speak in front of a partner, difficulty adhering to a treatment regimen, canceled appointments, illogical explanations for injuries, self-medication, and repeated presentation with sexually transmitted infections.<sup>8,9,46</sup>

Providers should ask patients who present with signs and symptoms of IPV follow-up questions about how they handle stress, their personal relationships, and conflict at home. Patients who screen positive for IPV should be referred to a mental health specialist. Similar to HIV disease, however, IPV signs and symptoms may not be immediate. "Providers need to be aware of triggers or cues of past trauma," warns Mugavero, who adds:

*I had a patient who had an undetectable viral load, adhered to his medication, came to appointments, and on the whole was doing well. He had a new boss at work [who] reminded him of a family member who had abused him as a child. Suddenly, he wasn't taking his meds; he was missing appointments, and his health was declining. At first we didn't know what was wrong. The trauma happened 30 years ago, but he was barely able to go to work—barely able to take care of himself. Fortunately, he communicated what was going on and we were able to get him connected with a mental health professional.*

### **PTSD Screening**

IPV and substance abuse screenings are more common than PTSD screenings. Patients who screen positive for IPV or substance abuse are often referred to a mental health professional, who subsequently screens them for PTSD. However, patients can be screened up front for PTSD and then referred to a specialist.<sup>41</sup>

Screening for PTSD should include gathering information about the patient's prevalence of nightmares, avoidance of particular situations or places, feelings of being on guard, sense of detachment from others, and physiological changes. Questions can also relate to



The HRSA HIV/AIDS Bureau's Special Projects of National Significance program is addressing IPV through its Women of Color initiative, which is scheduled to begin in the fall of 2009. The goal of the initiative is to enhance access to and retention in HIV services for women of color. Part of the initiative's comprehensive focus includes addressing sexual and physical abuse in communities of color and examining PTSD's effects on medication adherence. Planning for the initiative was a Federal interagency effort that included representatives from HRSA, the Centers for Disease Control and Prevention, and the Substance Abuse and Mental Health Services Administration. Grantees will be culturally competent demonstration projects targeting racial and ethnically diverse women and their families.

whether patients have ever been attacked or raped or have witnessed such events or whether they have ever been in a life-threatening event in which they thought they might be seriously injured or killed.<sup>35,38</sup>

Standardized screening methods to measure PTSD and other stress and anxiety disorders include the Beck Depression Inventory, the Posttraumatic Stress Checklist, and the Stanford Acute Stress Questionnaire.<sup>36</sup> The Posttraumatic Stress Checklist-Civilian (PCL-C) assesses PTSD symptoms and has been highly effective in identifying PTSD. Routine screening of PTSD and other mental health disorders is a critical first step in improving health and quality of life of PLWHA living with these conditions.<sup>36</sup> (Go to [www.dvs.virginia.gov/woundedwarrior/pdf/3-PTSDCheckListScoring.pdf](http://www.dvs.virginia.gov/woundedwarrior/pdf/3-PTSDCheckListScoring.pdf) to view the PCL-C.)

### **Linkages and Referrals**

Creating and maintaining linkages with other community stakeholders is key to effective treatment of IPV survivors. Important relationships include those with legal aid resources; law enforcement; child protective services; local housing organizations; employment and educa-

tional services; domestic violence hotlines; substance abuse treatment facilities; food banks; clothing, rent, and transportation assistance services; dating violence awareness classes; and, of course, domestic violence shelters.<sup>44</sup> Domestic violence shelters, however, may not be available for male IPV survivors of any orientation.

One Boston partnership links physicians and lawyers who collaborate in the emergency medicine department of a large urban hospital; there, lawyers assist women with obtaining temporary restraining orders without ever having to leave the hospital.<sup>13</sup> Integration of IPV intervention practices into various departmental programs extends to primary medical care, prenatal care, mental health, and alcohol and drug treatment.<sup>44</sup>

Just as IPV screening can be offered during HIV testing, so too can HIV prevention information and testing referral be provided during domestic violence programs' intake process (whether residential or nonresidential).<sup>48</sup> Domestic violence shelters are social service entry points for survivors of IPV that offer access to safe housing, which can play a major role in whether survivors will leave a violent environment.<sup>15</sup>

## ➔ ONLINE RESOURCES

*National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings:* <http://endabuse.org/userfiles/file/Consensus.pdf>

Screen to End Abuse: [http://endabuse.org/section/programs/health\\_care/\\_medscape](http://endabuse.org/section/programs/health_care/_medscape)

*Guidelines for Integrating Domestic Violence Screening into HIV Counseling, Testing, Referral and Partner Notification:* [www.health.state.ny.us/nysdoh/rfa/hiv/guide.htm](http://www.health.state.ny.us/nysdoh/rfa/hiv/guide.htm)

### Therapy

“One way we work with IPV patients is to look at what their goals are,” says Damm. “We do this through Socratic questioning, asking how violence is hindering their goals, and we provide psychoeducation. In terms of therapy, we have a multipronged approach with individual or group psychotherapy, wellness programming, and psychotropic medication.”

Counseling can include education in building self-esteem and healthy relationships. “We assist patients in identifying what a healthy relationship looks like,” Cobb says. “For women just coming out of violent relationships, we discuss condom use and how to talk about it with their next significant other. For some women, they can use not wanting to get pregnant as a reason to introduce condoms, particularly if this reasoning supports something that the abuser, or other partner, wants.”

Not only do survivors of IPV need therapy, but perpetrators of IPV need help, too, particularly in assuming personal responsibility for their behaviors. One effective strategy for perpetrators is to have them sign a contract stating that they will not impose violence within current or future relationships and that they will report any incidents to their therapist. For both survivors and batterers, therapy needs to focus on building social skills and

coping mechanisms. Counseling sessions are most successful if they are done privately as opposed to couples counseling with the survivor and abuser.<sup>8</sup>

Because of the high prevalence of PTSD among IPV survivors, a component of addressing IPV may also include treating PTSD. Therapy for PTSD needs to focus on addressing trauma-related symptoms associated with abuse experiences (e.g., avoidance). Patients need help identifying triggers; reducing isolation; developing coping skills; and focusing on healthy lifestyle choices such as diet, exercise, and regular sleep as well as breathing exercises and other relaxation techniques.<sup>39</sup>

PTSD-related anxiety may include anxiety over death stemming from HIV status as well as anxiety from having experienced violence. Helping patients find meaning in their lives and share their experiences and feelings with others in forums such as group psychotherapy with other survivors of IPV can validate their experiences and reduce the sense of isolation and helplessness that many IPV survivors have.<sup>40</sup> For some patients, however, group therapy may be too much to handle; providers need to evaluate on a case-by-case basis.<sup>32</sup>

Treatment\* for PTSD may include cognitive-behavioral therapy and pharmacotherapy with medications such as sertraline (Zoloft, Lustral), paroxetine\*\* (Seroxit, Paxil), or other selective serotonin reuptake inhibitor (SSRI) antidepressants.<sup>35,41,43</sup> Therapy may include tricyclic antidepressants, topiramate (Topamax) or other anticonvulsants, beta blockers, psychodynamic therapy, and eye-movement desensitization and reprocessing therapy (thought to assist in processing ideas and resolving conflicts). In some cases, benzodiazepines are used to counter anxiety-related symptoms; but their use should be short term and closely monitored because drugs in this class have high abuse potential. Benzodiazepines should never be first-line therapies.<sup>35</sup> PTSD interventions might also include exposure therapy using in vivo imaging, anxiety management, or multidimensional treatment packages that combine therapies.<sup>22</sup>

Addressing PTSD often involves phases: The *stabilization phase* addresses issues such as substance abuse and regulating emotions, the *integration phase* focuses on traumatic memories, and the *postintegration phase* helps patients learn new skills and coping behaviors.<sup>32</sup>

\*Some interactions between the medications listed here and HIV medications may increase or decrease antidepressant levels; therefore, medications should always be reviewed on a case-by-case basis before prescribing.

\*\*Sertraline and paroxetine are the only FDA-approved medications for PTSD. Paroxetine should not be used in patients under age 18. All SSRIs, however, can be helpful in treating symptoms of depression and anxiety that may accompany PTSD.

Patients experiencing PTSD, however, may never reach full remission: An estimated 50 percent of all PTSD cases are chronic.<sup>38</sup> Patients who have experienced multiple traumatic events (i.e., those with “complex PTSD”) are more difficult to treat than patients who have experienced just one traumatic event (i.e., those with “simple PTSD”). In fact, complex PTSD shares some symptoms with borderline personality disorder in terms of psychological development, particularly as it relates to identity and interpersonal relationships.<sup>30</sup>

## CONCLUSION

*What distinguishes domestic violence is its hidden, repetitive character and its immeasurable ripple effects on our society and on family life. It cuts across class, race, culture, and geography, and is all the more pernicious because it is so often concealed and so frequently goes unpunished.*<sup>49</sup>

The ramifications of IPV on PLWHA are numerous and significant. IPV can inhibit access to medical care and, thus, impede medication adherence and immune functioning while increasing HIV progression. And IPV

often involves comorbidities that are hard to treat individually and are all the more complex when considered together. Yet, recognizing the interplay of IPV, substance abuse, PTSD, depression, and past history of childhood sexual abuse can go far in effectively diagnosing—and treating—PLWHA. It also ensures that providers do not merely treat injuries and illnesses but address the underlying violence that causes or contributes to them.

Early detection of IPV can help improve health outcomes. In addition, the better providers understand IPV, the more they can educate patients, partners, and other community stakeholders about prevention and harm-reduction techniques. Understanding IPV goes beyond surveillance data, however. It means being cognizant that the same coping mechanisms survivors use to numb themselves and escape from feelings of abuse are the very same behaviors that place them at increased risk for revictimization.

But the cycle can be broken. Through therapy, support, and safety-planning measures, patients can walk away from violent relationships and homes and begin to lead happier, healthier lives.



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