From Treatment To Healing

The Promise of Trauma-informed Care

Annual HIV/AIDS Update
North Coast Area AIDS Education & Training Center
Saturday April 30, 2016

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Objectives

• Identify the prevalence and impact of trauma/PTSD on women living with HIV

• Review approaches to facilitate healing from past abuse and preventing re-victimization
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• Review approaches to facilitate healing from past abuse and preventing re-victimization
The Women’s HIV Program at UCSF

One of the first programs in country for WLHIV
Female-focused services provided in a “one-stop shop”

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Gynecology</th>
<th>Obstetrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy program</td>
<td>Social Work</td>
<td>Case Management</td>
</tr>
<tr>
<td>Therapy/Psychiatry</td>
<td>Breakfast</td>
<td>Partner agencies in clinic</td>
</tr>
</tbody>
</table>

**Patients**
- Mostly African American or Latina (20% White). 15% transgender women
- 15-71 years old
- Marginally housed, low income
- Medically and psycho-socially complex
Recent Deaths at WHP

1. Rose murder
2. Amy murder
3. Patricia suicide
4. Regina suicide
5. Vela suicide
6. Iris addiction/overdose
7. Mary addiction/organ failure
8. Nadine addiction/lung failure
9. Lilly pancreatic cancer
10. Pebbles non-adherence

Photo by Lynnly Labovitz; used with artist and patient permission
Trauma

“... an event, series of events, or set of circumstances [e.g., physical, emotional and sexual abuse; neglect; loss; community violence, structural violence, war] that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being”.

A few more important definitions

**Complex Trauma**: repeated trauma, physically or emotionally (e.g., repeated childhood physical and/or sexual abuse, witnessing ongoing IPV, experiencing long-term IPV)

**PTSD**: includes 4 types of symptoms: 1) re-experiencing of the traumatic event(s); 2) avoidance of situations that remind you of the event; 3) negative changes in the way you think about yourself, other people or the world, and 4) feeling “keyed up”.

**Complex PTSD**: Includes all of the symptoms of PTSD + trouble regulating and handling emotions and relationships, and feelings of low self-worth and powerlessness

Rates of trauma and PTSD in WLHIV are much higher

Meta-analysis of all studies among US WLHIV

<table>
<thead>
<tr>
<th>Categories</th>
<th>Number of Studies</th>
<th>Pooled n</th>
<th>Prevalence (%)</th>
<th>95% Confidence Interval</th>
<th>Reference Prevalence</th>
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</thead>
<tbody>
<tr>
<td>Intimate Partner Violence</td>
<td>8</td>
<td>2285</td>
<td>55.3</td>
<td>36.1 - 73.8</td>
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<tr>
<td>Childhood Sexual Abuse</td>
<td>7</td>
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<td>31.5 - 54.4</td>
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</tr>
<tr>
<td>Childhood Abuse Unspecified</td>
<td>2</td>
<td>232</td>
<td>58.2</td>
<td>36.0 - 78.8</td>
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</tr>
<tr>
<td>Lifetime Sexual Abuse</td>
<td>8</td>
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<td>1065</td>
<td>71.6</td>
<td>61.0 - 81.1</td>
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<tr>
<td>Recent PTSD</td>
<td>6</td>
<td>499</td>
<td>30.0</td>
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29 studies met our inclusion criteria, resulting in a sample of 5,930 individuals.

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Recent Trauma → 4x the rate of ART Failure

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<th>Potential factors</th>
<th>Detectable viral load on ART</th>
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<tr>
<td>Age (increase of one year)</td>
<td>OR 1.0 (0.93-1.1; p=.96)</td>
</tr>
<tr>
<td>African-American</td>
<td>OR 1.8 (0.6-6.1; p=.32)</td>
</tr>
<tr>
<td>Transgender</td>
<td>OR 0.9 (0.2-3.2; p=.84)</td>
</tr>
<tr>
<td>CD4 count &lt;200 cells/µl</td>
<td>OR 2.1 (0.7-6.5; p=.20)</td>
</tr>
<tr>
<td>&lt;90% ART adherence</td>
<td>OR 1.0 (0.3-3.6; p=.97)</td>
</tr>
<tr>
<td>Depression</td>
<td>OR 0.8 (0.3-2.7; p=.78)</td>
</tr>
<tr>
<td>Low self-efficacy</td>
<td>OR 1.7 (0.4-8.1; p=.50)</td>
</tr>
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<td>Low social support</td>
<td>OR 2.2 (0.6-6.9; p=.18)</td>
</tr>
<tr>
<td>Drug use</td>
<td>OR 1.1 (0.4-3.4; p=.88)</td>
</tr>
<tr>
<td>Lifetime coerced sex</td>
<td>OR 1.2 (0.4-3.8; p=.78)</td>
</tr>
<tr>
<td>Recent coerced sex</td>
<td>OR 1.8 (0.3-12.0; p=.53)</td>
</tr>
<tr>
<td>Lifetime trauma</td>
<td>OR 1.2 (0.3-4.5; p=.77)</td>
</tr>
<tr>
<td><strong>Recent trauma</strong></td>
<td><strong>Odds ratio 4.3</strong></td>
</tr>
<tr>
<td></td>
<td>(1.1-16.6; p=.04)</td>
</tr>
</tbody>
</table>

The HIV Care Continuum in the United States, 2011.

The HIV Care Continuum in the United States, 2011.

IPV/recent trauma

- 3x more likely to wait >90 days*
- ≈ 2x rate of lost-to-follow
- ≈ 2X missed gyn appts
- ½ as likely on ART*
- ½ as likely on ART
- 2x non-adherence*
- 2x non-adherence
- 2-3x non-adherence*
- >1.3x rate of failure
- >2x rate of failure
- >4x rate of failure

* Includes both men and women
+ Meta-analysis
† Includes “Stressful Life Events

Siemieniuk RA, et al. AIDS Patient Care STDs. 2010*
Kalokhe, A.S., et al. AIDS Patient Care and STDs. 2012*
Hatcher, A.M., et al. AIDS. 2015*
Lesserman, J. et al. AIDS PATIENT CARE and STDs. 2008*

Mugavero M, et al. Barriers to antiretroviral adherence: the importance of depression, abuse, and other traumatic events. AIDS patient care and STDs. 2006 Jun;20*


1.7 greater odds of not being on HAART when medically indicated

Significant association of numbers of lifetime traumas and ART nonadherence: OR 1.14, (95% CI 1.05, 1.25) *

Significant association of numbers of lifetime traumas and ART nonadherence: 1.13 (95% CI 1.03, 1.24) *
Ratios depicted are for illustrative purposes only and are not based on attributable risk data.
The HIV Care Continuum in the United States, 2011.

- HIV Diagnosed: 86%
- Linked to Care: 80%
- Engaged in Care: 40%
- Prescribed ART: 37%
- Virally Suppressed: 30%

Ratios depicted are for illustrative purposes only and are not based on attributable risk data.
The HIV Care Continuum in the United States, 2011.

Percent of all People Living with HIV

- HIV Diagnosed*: 86%
- Linked to Care**: 80%
- Engaged in Care***: 40%
- Prescribed ART***: 37%
- Virally Suppressed***: 30%

Ratios depicted are for illustrative purposes only and are not based on attributable risk data.
Impact of trauma on other HIV-specific outcomes

Recent or lifetime trauma associated with:

- **HIV risk factors/HIV incidence**

- **Faster disease progression**
  Mugavero, MJ, et al. AIDS Patient Care STDS 2007 Sep;21(9):681-90.] *

- **More hospitalizations**

- **Almost twice the rate of death***

* Study included both men and women
Predictors of Mortality in WLHIV over time

**Women’s Interagency HIV Study**

By 2012, ≈ 17% deaths were AIDS-related*

**Women’s HIV Program at UCSF**

- Only 3/19 (16%) deaths over past decade were likely due to HIV/AIDS.
- Others: violence (2/19), suicide (3/19), substance abuse (5/19), cancer (2/19), lung disease (1/19), car accident (1/19), or unknown (2/19).

*Personal Communication, Kathleen Weber, Women’s Interagency Study, October 9, 2015
¶Cocohoba, J, Chiarelli, B, Machtinger, E.10th Conference on HIV Treatment and Prevention Adherence 2015


Research using a wide range of trauma groups has shown that harms to effective delivery of treatment, such as treatment dropout and a failure to engage with treatment, can often be predicted by initial levels of depression in individuals with post-traumatic stress disorder (PTSD). According to Bryan, Snodgrass, Deng, & Nissen, 2000; Forbes, Creamer, Hawke, Moloney, & Eysenck, 2010 & 2011; McLaughlin et al., 2001; Taylor et al., 2001, it is possible that depression can make it difficult for individuals to engage with cognitive-behavioral therapy (CBT), especially if they are placed under stress or under pressure to succeed. However, in the current study, the pilot study is not large enough to make predictions on the basis of present findings. Nevertheless, the study shows that depression has an effect on engagement with treatment. Therefore, it is important to consider the role of depression in the treatment of PTSD.

From an evidence-based perspective, RA has accumulated significant empirical support for the treatment of PTSD (see Emslie et al., 2003; Gerson, Grunke, & Silberman, 1999; Jacobson, 1999). RA is founded on the premise that avoidance techniques release negative emotions by reducing re-experiencing and reactivating traumatic memories. Increasing anxiety and associated behaviors such as anamnesis, dreamwork, and avoidance (which seemingly or indirectly with action can reduce depression (Mander, Widows, & Jacobs, 2011). Anxiety is an especially prominent issue in PTSD. In the study, PTSD is not large enough to make predictions on the basis of present findings. Nevertheless, the study shows that depression has an effect on engagement with treatment. Therefore, it is important to consider the role of depression in the treatment of PTSD.

The efficacy of a cognitive-behavioral treatment program for individuals with concurrent posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) was examined in an uncontrolled pre-post treatment study. Participants attended 12-15 weeks of behavioral therapy incorporating behavioral activation for depression in early sessions and exposure therapy and cognitive restructuring for PTSD in later sessions. Twenty participants (28% of all PTSD patients) indicated a significant decrease in PTSD and depression severity between pre- and posttreatment assessment. PTSD increased further from stage 1 to posttreatment. Treatment gains were maintained at 6-month follow-up. 66% of participants no longer met PTSD criteria at 6-month follow-up, and 30% no longer met MDD criteria. The clinical implications of this pilot approach to treatment of PTSD and depression are discussed.


SUD and depression more effectively treated if trauma is addressed
Objectives

• Identify the prevalence and impact of trauma/PTSD on women living with HIV

• Review approaches to facilitate healing from past abuse and preventing re-victimization
Evidence-based interventions exist: IPV

**Screening tools are accurate**: fifteen studies evaluated 13 screening instruments, and six instruments were highly accurate;

**Interventions can reduce IPV**: four fair- and good-quality RCTs reported reduced IPV and improved birth outcomes for pregnant women, reduced IPV for new mothers, and reduced pregnancy coercion and unsafe relationships for women in family-planning clinics;

**Screening for IPV is safe**: fourteen studies indicated minimal adverse effects with screening

**Screening alone without an intervention does not appear to be better than usual care**

Interventions exist: lifetime trauma and PTSD

National Registry of Evidence-Based Program and Practices (US):
24 interventions for various types lifetime trauma; 14 for PTSD

Examples Include:*
- Trauma-specific cognitive behavioral therapy (CBT)
- Prolonged Exposure Therapy for PTSD
- Trauma-specific social support/expressive therapy

Medications
- Eye Movement and Desensitization and Reprocessing (EMDR)
- Mindfulness/yoga

Seeking Safety
- Skills Training in Affective & Interpersonal Regulation (STAIR)
- Living in the Face of Trauma (LIFT)

* = not comprehensive; some listed are not included on SAMHSA site
**“Seeking Safety” for Transgender WLHIV**

**Participants:** 7 transgender WLHIV with recent substance use and recent or past trauma

**Content:** 12 *Seeking Safety* modules based on appropriateness for transgender WLHIV

**Incentives:** $180 for completion of 12 sessions.

**Outcome Measures:** PTSD symptom (PCL-C 17), alcohol and drug use (MAST-22, DAST-20), and HIV stigma (HIV Stigma Scale) scales pre and post-intervention.

<table>
<thead>
<tr>
<th></th>
<th>PCL-C 17</th>
<th>MAST</th>
<th>DAST</th>
<th>HIV Stigma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>1</td>
<td>64</td>
<td>58</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>35</td>
<td>32</td>
<td>3</td>
<td>1</td>
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<td>3</td>
<td>32</td>
<td>25</td>
<td>3</td>
<td>2</td>
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<tr>
<td>4</td>
<td>70</td>
<td>66</td>
<td>15</td>
<td>13</td>
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<tr>
<td>5</td>
<td>68</td>
<td>36</td>
<td>3</td>
<td>4</td>
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<tr>
<td>6</td>
<td>59</td>
<td>57</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>60</td>
<td>46</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>AVG (SD)</td>
<td>55.4 (15.5)</td>
<td>45.7 (15.3)</td>
<td>7.1 (4.9)</td>
<td>5.4 (4.5)</td>
</tr>
<tr>
<td>Percent Change (SD)</td>
<td>17.50%</td>
<td>23.90%</td>
<td>68.80%</td>
<td>3.50%</td>
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**Table 1. Five Impact themes**

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<th><strong>Sisterhood</strong></th>
<th>The formation of deep, honest, and supportive relationships among group members</th>
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<td><strong>Catharsis</strong></td>
<td>Freedom from the burden of secrecy about HIV, childhood and adult traumas, and other stigmatizing experiences</td>
</tr>
<tr>
<td><strong>Self-acceptance</strong></td>
<td>Reframing the understanding of what it means to be a woman living with HIV, normalizing life with HIV and embracing a stronger and more positive self-identity</td>
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<tr>
<td><strong>Safer and healthier relationships</strong></td>
<td>Developing safe, honest, authentic, and fulfilling relationships</td>
</tr>
<tr>
<td><strong>Gaining a voice</strong></td>
<td>Gaining a sense of purpose and accomplishment as an educator and activist and the skills and confidence to change the social norms that create trauma, stigma, isolation, and HIV risk</td>
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- 4 of 8 initial participants reported leaving or avoiding abusive relationships as a result of the intervention.

An expressive therapy group disclosure intervention for HIV-positive women improves social support, self-efficacy, and the safety and quality of relationships: a qualitative analysis. JANAC. June, 2014.
A nationally recognized issue
Now specifically recognized in WLHIV

Recommended Action 2.2:

“Develop, implement, and evaluate models that integrate trauma-informed care into services for women living with HIV”.

Addressing the Intersection of HIV/AIDS, Violence against Women and Girls, & Gender-Related Health Disparities

Interagency Federal Working Group Report

September 2013
Goal 2, Step C.2:

“Improve outcomes for women in HIV care by addressing violence and trauma and factors that increase risk of violence for women and girls living with HIV”
A model based on evidence and experience

- Expert meeting
- Follow-up consultations
- Literature review
- Identified existing evidence-based strategies to use as building blocks
What are trauma-informed values?

1. Safety
2. Trustworthiness and Transparency
3. Peer support
4. Collaboration instead of hierarchy
5. Empowerment, Voice and Choice
6. Cultural, Historical and Gender Understanding

SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach. 2014
What is Trauma-informed care?

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.

SAMHSA's Concept of Trauma and Guidance for a Trauma-informed Approach. 2014
Trauma-informed Primary Care

SCREENING
Inquiry about current & lifelong abuse, PTSD, depression and substance use.

RESPONSE
Onsite and community-based programs that promote safety and healing.

FOUNDATION
Trauma-informed values, robust partnerships, clinic champions, support for providers and ongoing monitoring and evaluation.

Environment
Calm, safe, empowering for both patients and staff.

Our Clinic

Response – IPV

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<th>TIPC</th>
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| Coordinated interdisciplinary response to positive screens; safety planning by social worker; referrals to IPV agencies, safe housing, and legal services; informal follow-up. | 1. **More formalized safety planning and Danger Assessment**  
Social worker use standardized safety plan and *Danger Assessment* and provide patients with a standardized list of resources |
|                                                                    | 2. **Formalized link with DV/legal agencies**  
DV agency to offer on-site assessment of positive screens and warm hand off for additional services. |
|                                                                    | 3. **Standardized documentation in EMR**  
Template created to facilitate documentation |
|                                                                    | 4. **Clinic-wide panel management of active IPV cases**  
Social worker and case manager to maintain list of active IPV cased; all discussed at quarterly IPV interdisciplinary interagency conferences and mentioned at every weekly preclinical meetings to ensue maximal care coordination. |
# Response – lifelong trauma

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| Onsite therapy; limited onsite psychiatry; referrals to partner mental health organizations; referrals to substance use treatment | **Improving Connections with Others**<br>1. Trauma-specific therapy  
Partnership with the *Trauma Recovery Center (TRC)* at SFGH. Menu of options for patients including STAIR Narrative Therapy and Seeking Safety.  
2. Peer-led empowerment, support and leadership training. Partnership with Positive Women’s Network-USA to run 12-session empowerment, disclosure and leadership curriculum. |
| **Improving Physiological Connections**                              | 3. Trauma specific psychiatry and EMDR  
Partnership with TRC and by enlisting our own psychiatrist. |
| **Improving Connections with Our Bodies**                            | 4. Body/Mindfulness-Focused Healing  
Mindfulness and yoga program during clinic (MBSR) |
What Can You Do Tomorrow?

First know this: the model is aspirational. Very few clinics have these services in place. These is an increasing awareness that trauma is important and treatable. In the meantime, You can

1. Stop and think about the connection between trauma and health. Realize that a lot about who we are and what we do are because of things that happened to us.

2. Distribute literature in the waiting room about the impact of trauma on health ➔ message to patients that you understand and care about this issue.

3. Get training about the impact of trauma on health, trauma-informed values and skills.

4. Practice talking with your patients about trauma.

Over time: a clinic champion can emerge; protocols for screening can be made, and responses to IPV and lifelong trauma can be developed in partnership local organizations and other like minded practitioners.
Getting to Zero
UNAIDS 2011-2015 STRATEGY

Ø Zero new HIV infections
Ø Zero AIDS-related deaths
Ø Zero discrimination

CAJP-OAS/ Washington, April 2011
Conclusions

• People can heal; deep cycles of violence can be broken; ACEs in children can be reduced, and entire communities can benefit by addressing trauma in adults.

• The problems faced by most of our patients can be more effectively treated if primary care becomes genuinely trauma-informed.

• TIPC holds the potential to transform the care-giving experience for providers, creating environments and supporting them to be healers.
Thank you for participating!