Speaker Name	Statement
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Why we need to think about trauma in HIV services

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Overview of session

- Define trauma
- Think about the many ways in which trauma is relevant to PLWHIV
- Think about why it is important that HIV services have an understanding of the impact of trauma
- How can services help people affected by trauma

Disclaimer – take care of yourselves

What is trauma?

- **Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM-5; 2013)**

CRITERION A

- *The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence (direct indirect)*

Trauma= Fear + Helplessness

Can a potentially life threatening illness count as a traumatic event?

What is trauma?

- **CRITERION B: Re-experiencing**
  - Intrusive thoughts, Nightmares, Flashbacks, Emotional distress and/or Physical reactivity after exposure to traumatic reminders

- **CRITERION C: Avoidance**
  - Avoiding trauma-related reminders or trauma-related thoughts and/or feelings

- **CRITERION D: Negative thoughts and feelings**
  - Overly negative thoughts (self and world), exaggerated blame (self or others), negative affect, loss of positive affect, reduced interest, feeling isolated

- **CRITERION E: Arousal**
  - Irritability, aggression, hypervigilance (monitoring for threat) heightened startle response, sleeping and concentration difficulties

What is trauma?

Criterion F

- Symptoms last for more than 1 month.
  - **(Presents similarly to Acute Stress Disorder – short term response to a traumatic event)**

Criterion G

- Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H

- Symptoms are not due to medication, substance use, or other illness.

- **RESILIENCE IS THE NORM**

How does trauma work?

- Many complex cognitive, emotional , physiological and behavioural processes involved

- Several theoretical viewpoints – e.g.
  - Horowitz (1975, 1976)
  - Shattered Assumptions – Janoff Bulman (1983)
  - Brewin et al (1996; 2010) – Information Processing and Dual Representation Theory
  - Foa et al (1989) – Fear Networks
  - Ehlers and Clark (2000)– Cognitive Model of PTSD

- ***Cumulative aspect – 'the kindling effect'***

Trauma and HIV

- HIV diagnosis can be traumatising
- People living with trauma may find it more difficult to manage a chronic condition (poorer health outcomes)
- People with a history of trauma are more vulnerable to HIV infection

Prevalence of Trauma in the HIV Population

- There is strong evidence that there is higher prevalence of mental health problems amongst people living with HIV compared with the general population (WHO, 2008).

- PTSD 33% more prevalent in HIV population (National Institute for mental health)

- PTSD prevalence rates – 10-74% - compared to 8% general population (Applebaum et al 2015)

Traumatic impact of HIV diagnosis

- **Shock** – highly stressful event
- **Fear of death**
  - 'a heavy history'
  - Previous direct exposure to HIV-related death
  - Lack of up to date treatment knowledge
- **Fear of loss**
  - Health, relationships, employment, future……
- **Fear of stigma, discrimination and isolation**
  - Including internalised stigma and self-directed shame
- **Fear of onward transmission** (partners, or mother to child)
- **Source of transmission** can enhance the trauma

Influence of history and context

- **Long term survivors**
  - Fear of death was very realistic
  - Multiple traumatic bereavements
  - Physical trauma of side effects of early medications
  - Rejection by society
  - Loss of significant others and survival guilt

- **Newly diagnosed people**
  - Very little information – no frame of reference
  - Less of a sense of community?

- **Asylum seekers**
  - High rates of trauma
  - Loss of family, friends and familiar base
  - ongoing insecurity about status

Influence of history and context

- **Older age**
  - Fears about going into care
  - Concerns about managing increasing co-morbidities
  - Dementia
- **Gender and sexuality**
  - Motherhood
  - Gender-based violence
  - LGBT related issues – e.g. persecution
- **Community**
  - Social norms and expectations
  - Attitudes
  - Religious frameworks

Traumatic impact of HIV-related ill health

- **Extreme ill health at time of diagnosis**
  - Unknown cause
  - ICU admission
  - Cognitive impairment

- **On going management of HIV – chronic stressor**
  - Constant fear of people finding out
  - Non-consent disclosures
  - Stigma and discrimination
  - Fear of missing medication doses – resistance
  - Hypervigilant research – with a 'fear filter'

Historical Trauma

- HIV diagnosis can exacerbate existing trauma
- HIV high prevalence in already marginalised groups (e.g. people with mental health issues, LGBT, asylum seekers)
- Historical trauma (mental health issues)
  - puts people at more risk of being infected with HIV
  - May increase risk of onward transmission
- Abuse in early life – particularly is by caregivers – can affect engagement with healthcare professionals
- Historical trauma may mean people have less helpful coping strategies after diagnosis/managing HIV

The complexities of 'unhelpful' coping

- **External coping**
  - Risk behaviours-sex, drugs, rock and roll
  - Historical trauma can manifest in relational issues –
    - Insecure template for relationships
    - exposure to unfulfilling relationships – chaotic, abusive
    - Distressing = familiar = safe
- Hep C, other STD's – compound the trauma via things such further concealment – shame
- Generally not looking after health – HIV, co-morbidities, or just general wellbeing (e.g. smoking, drinking, drug use)– impact on overall health outcomes

The complexities of 'unhelpful' coping

- **Internal coping**
  - Rumination
    - Doesn't solve the problem, just keeps mind on it – low mood
  - Hypervigilance
    - Constantly monitoring for threat
  - Self criticism
    - Feeds negative feelings, more unhelpful coping, further self criticism

- **Avoidance** (part of the trauma presentation)
  - Avoiding any reminders of the traumatic event, including own thoughts
  - Withdrawal
    - Isolation and not processing the trauma

- **Dissociation**

Trauma and Adherence

- Fear of side effects
- Chaotic lifestyle
- Medication as a trigger for overwhelming trauma memories and emotions
- Supporting a sense of denial
- Not taking ART may serve a function
  - Self punishment and/or self harm
  - Sense of control
- Worthlessness
- Hopelessness
- Lack of trust of health care professionals/system – affecting engagement
- **HOWEVER** – can also increase adherence

Vicarious Trauma/Secondary Traumatic Stress

- **Dealing with a population with complex psychosocial needs – impact on healthcare professionals**

- Overwhelmed
- Distressing emotional responses
- Negative thoughts about people/situations/world
- Trying to avoid certain people/situations
- Irritability/anger
- High work stress levels
- Loss of empathy
- Fear – from role pressures
- Work stress affecting sleep
- Things outside of work reminding you of work
- Periods of sick leave
- Helplessness
- Hopelessness?

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What Can HIV Services Do?

- Show compassion and give space
- Delivery of up to date information
  - Make sure people have been able to take information in (dissociation)
  - Provide written info, info sources, checking in regularly
- Get to know the signs of trauma – trauma screening questionnaire?
- Signpost as necessary
- Seek consultation and/or supervision
- Be aware of power dynamics – impact of our 'status'
- Be consistent – across the team
- Take care of ourselves and each other
- Don't force 'de-briefs'

Psychological first aid

- Empathy and compassion
- Listen
- Re-assure
- respond

Post Traumatic Growth

- **HIV diagnosis can:**
  - Help people find a community
  - Access support
  - Perspective shift – changing life choices

- **The care team can:**
  - Function as a ‘safe base’ for those with difficult histories
  - Help a person learn how to develop; and manage relationships
  - Help people learn to care for themselves
  - Aid an overall recovery

Thank you for listening

Questions?

References

- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.
- Applbaum, A. J., Andres Bedoya, C., Hendriksen, E. S., Wilkinson, J. L., Safren, S. A., & O'Cleirigh, C. (2015). Future directions for interventions targeting PTSD in HIV-infected adults. Journal of the association of nurses in AIDS care, 26, 127-138.
- Boarts, J. M., buckley-Fishcher, B. A., Armelie, A. P., Bogart, L. M. & Delahanty, D. L. (2017). The impact of HIV diagnosis related trauma on PTSD, depression, medication adherence, and HIV disease markers. Journal of evidence-based social work, 6, 4-16.
- Brewin, C. R., Dalgleish, T., & Joseph, S. (1996). A dual representation theory of posttraumatic stress disorder. Psychological review, 103, 670-686.
- Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: Characteristics, neural mechanisms and treatment implications. Psychological review, 117, 210-232.
- Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S., & Foa, E. B. (2002) Brief screening instrument for post-traumatic stress disorder. Journal of psychiatry, 181, 158-162.
- Ehlers, A., & Clark, D. M. (2000). A Cognitive Model of posttraumatic stress disorder. Behaviour, research and therapy, 38, 319-345.

References

- Foa, E. B., Steketee, G., & Olasov-Rothbaum, B. (1989). Behavioral/cognitive conceptualizations of post-traumatic stress disorder. *Behavior therapy, 20*, 155-176.
- Flentroy, S. L., Young, M., Blue, N., & Gilbert, D. J. (2015). Innovative assessment of childhood trauma and it's link to HIV and substance abuse in post-incarcerated women. *Journal of creativity in mental health, 10,* 351-362.
- Horowitz, M., J. (1986) Stress-response syndromes: A review of Posttraumatic and adjustment disorders. *Psychiatric services, 37*, 241-249.
- Janoff-Bulman, R. (1989). Assumptive Worlds and the Stress of Traumatic Events: Applications of the Schema Construct . *Social Cognition. 7*, 117.
- Kagee, A. (2008). Application of the DSM-IV criteria to experience of living with AIDS: Some concerns. *Journal of health psychology, 13,* 1008-1011.
- Kamen, C., Bergstrom, J., Vorasarun, C., Mardini, M., Patrick, R., Lee, S., Lazar, R., Koopman, C., & Gore-Felton, C. (2013). The impact of childhood bullying among HIV positive men: Psychosocial correlates and risk factors. *Child abuse and neglect, 37*, 273-281.
- Katz, S., & Nevid, S. J. (2005). Risk factors associated with posttraumtic stress disorder symptomatology in HIV-infected women. *AIDS patient care and STDs, 19*, 110-120.
- Kelly, B., Raphael, B., Judd, F., Perdices, M., Kermutt, G., Burnett, P., Dunne, M., & Burrows, G. (1998). Posttraumatic stress disorder in response to HIV infection. *General hospital psychiatry: Psychiatry medicine and primary care, 20,* 345-352.

References

- Nightingale, V. R., Sher, T. G., & Hansen, N. B. (2010). The impact of receiving an HIV diagnosis and cognitive processing on psychological distress and posttraumtic growth. Journal of traumatic stress, 23, 452-460.
- Orton, L., Griffiths, J., Green, Maia., & Waterman, H. (2012). Resilience among asylum seekers living with HIV. BMC publi health, 12, 926.
- Peltzer, K., Matseke, G., & Louw, J. (2014). Secondary trauma and job burnout and associated factors among HIV lay counsellors in Nkangala district, South Africa. British journal of guidance and counselling, 42, 410-422.
- Pence, B. W. (2009). The impact of mental health and traumatic life experiences on antiretroviral treatment outcomes for people living with HIV/AIDS. Journal of antimicrobial chemotherapy, 63, 636-640.
- Radcliffe, J., Beidas, R., Hawkins, L., & Doty, N. (2011). Trauma and sexual risk among sexual minorty African American HIV-positive young adults. Traumatology, 17, 24-33.
- Safren, S. A., Gershuny, B. S., & Hendriksen, E. (2003). Symptoms of posttraumatic stress and death anxiety in persons with HIV and medication adherence difficulties. AIDS patient care and STDs, 17, 657-664.
- Sherr, L., Nagra, N., Kulubya, G. Catalan, J., Clucas, C., & Harding, R. (2011). HIV infection associated post-traumatic stress disorder and post-traumatic growth – A systemic review. Psychology, health and medicine, 16, 612-629.

References

- Watt, M. H., Dennis, A. C., Choi, K. W, Ciya, N., Joska, J. A., Robertson, C., Sikkeman, K. J. (2016). Impact of sexual trauma on HIV care engagement: Perspectives of female patients with trauma histories in cape town, South Africa. AIDS and behaviour, DOI 10.1007/s10461-016-1617-1.
- Zeligman, M., Barden, S. M., & Hagedorn, W. B. (2016). Posttraumatic growth and HIV: A study on associations of stigma and social support. Journal of counseling and development, 94, 141-149.